AUTHORIZATION TO RELEASE HEALTHCARE INFORMATION

DR ALEKSANDR PODOLSKIY
755 S MILWUAKEE AVE STE 164, LIBERTYVILLE, IL 60048
Phone: 847-918-0430 Fax: 847-918-0436

Patient's Name: _____ Date of Birth: _____

Previous Name: _____ Social Security #: _____

I above hereby authorize and request the release of my medical records from the following facility and/or providers:

Name: _____

Address: _____

City: _____ State: _____ Zip Code: _____

Phone: _____ Fax: _____

This request and authorization applies to:

○ **Healthcare information relating to the following treatment, or condition:**
○ **All healthcare information dating back _____years.**
○ **Other:**

Patient Signature: _____

Date Signed: _____/_____/20_____

PLEASE FAX BACK THESE REQUESTED RECORDS TO

847-918-0436