

**Release of Medical Records to us**

To: \_\_\_\_\_  
(Doctor/Hospital)

Street Address: \_\_\_\_\_

City: \_\_\_\_\_ State: \_\_\_\_\_ Zip \_\_\_\_\_

Phone: \_\_\_\_\_ Fax: \_\_\_\_\_

I hereby authorize the release of my medical records:

\_\_\_\_\_ All Records          \_\_\_\_\_ Progress Notes          \_\_\_\_\_ Lab Tests

\_\_\_\_\_ Diagnostic Tests          \_\_\_\_\_ -----  
(Specify)

From: \_\_\_\_/\_\_\_\_/\_\_\_\_ to \_\_\_\_/\_\_\_\_/\_\_\_\_ and request to send it to:

**Yorkville Internists, SC**  
**2720 East New York Street**  
**Suite 108**  
**Aurora, IL 60502**  
**Phone: (630) 820-7045**  
**Fax: (630)820-7047**

Name of Patient: \_\_\_\_\_ Date of birth: \_\_\_\_/\_\_\_\_/\_\_\_\_  
Last First MI mm dd yy

Signature: \_\_\_\_\_ Date: \_\_\_\_/\_\_\_\_/\_\_\_\_  
Patient or Guardian

Complete this form and send to the doctor or hospital to request records send to our office