Action PHYSICAL MEDICINE & REHABILITATION

Records Release Form

Request Date: _____

Patient Name: _____ Date of Birth: _____

Home Address: _____

I hereby authorize and request the release of medical records to:

Dr. John Mikuzis, D.O.

At any of the following facility:

1315 Macom Dr., Suite 005; Naperville, IL 60564. Phone: (630) 904-5640 Fax: (630) 470-9298

1890 Silver Cross Blvd., Pavilion A, Suite 425, New Lenox, IL 60451. Phone: (815) 725-4918 Fax: (779) 803-3278

I understand that uses and disclosures may only be made by, and only to, the persons or organizations identified below.

INFORMATION TO BE RELEASED FROM:	**INFORMATION TO BE RELEASED TO:**
	Action P M & R
Organization/Person Name	Organization/Person Name
Street Address	Street Address
City, State, Zip	City, State, Zip
Telephone/Fax #	Telephone/Fax #

Date range of information needed:_____

Specify information which can be disclosed by checking the boxes:

- ☐ ANY and ALL medical information in the office records set is to be made available.
- ☐ History/Progress notes
- ☐ Labs/X-rays, MRIs & other tests
- ☐ Other/Specific:_____

- I understand that if these records include information pertaining to sensitive records, including drug and/or alcohol abuse, mental health (may include pain management or psychiatry records), & sexually transmitted diseases including AIDS/HIV, this information will be released as part of my record.
- I understand that my decision to sign this form and authorize this use and disclosure of health information about me is entirely voluntary.
- I understand that my refusal to sign this form will not affect my ability to receive treatment.
- I understand that information used or disclosed pursuant to this authorization may be disclosed by the recipient and may no longer be protected by federal or state law.
- I understand that I may revoke this authorization, in writing, at any time. However, such a revocation will not be effective for uses or disclosures that have already been made or other actions that have already been taken, in reliance on this authorization or as required by law. I may make such a written revocation by mailing it to, or presenting it in person at either Action PM&R location.
  *****Unless revoked by me, this authorization shall be effective for one year after the date of my signature below.***

I acknowledge I have fully reviewed and understand the contents of this authorization form. My signature below indicates that I agree and authorize to release of records to the above named person or organization.

Patient or Legal Guardian Signature:_____ Date: _____

Witness Signature: _____ Date: _____