

Authorization for Release of Information

Date: \_\_\_\_\_

To: \_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

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

I authorize the release of my records indicated below from/to:

**Group Business Title**

Balance Health + Wellness  
1901 North Clybourn, Suite 301  
Chicago, IL 60614  
773-472-0560 phone  
773-472-0429 fax

- All Medical Records
- X-Rays
- All Imaging Reports
- Blood Analysis
- Other: \_\_\_\_\_

Patient Signature: \_\_\_\_\_

Patient Name: \_\_\_\_\_

Home Address: \_\_\_\_\_

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

Daytime Phone: \_\_\_\_\_

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

Fax Sent: \_\_\_\_\_ Date: \_\_\_\_\_ By: \_\_\_\_\_

Records Received: \_\_\_\_\_ Date: \_\_\_\_\_