Authorization to Release Protected Health Information

Instructions: If any section is incomplete, this form may be invalid.

Name: (First, Middle, Last) (PLEASE PRINT)	Birth Date (Month, DD, YYYY)	Phone No.: (_____) _____ - _____
Address	City, State, Zip Code	

[redacted]

Shirley Ryan AbilityLab
355 E. Erie Street, Chicago, IL 60611

_____

_____

_____

_____

_____ _____

_____ _____

Treatment/Continued Care Personal Legal Purposes

SD Insurance _____

INFORMATION TO BE RELEASED (CHECK ALL THAT APPLY AND INITIAL)

Progress Notes Operative/Procedure/Pathology Reports Lab Results

Diagnostic/Radiology Billing Information

Other: _____

The follii Vocational Rehab Chaplaincy Notes

_____

Paper copies of the requested information will be mailed to the address above, unless one or more of the following options are selected:

Provide on CD Pick-up E-mail: _____

I can revoke (take back) this Authorization at any time in writing to the Shirley Ryan AbilityLab Director of Medical Records, except to the extent that action has already been taken to release this information. This Authorization will remain valid unless revoked, but will expire 1 year after the date below. I can inspect a copy of my health information to be released. If I do n

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