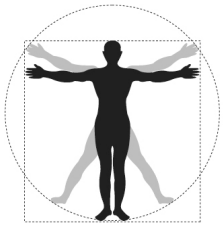

Allied Healthcare
ASSOCIATES

Records Release Form

Please complete all information on this form to assure accurate transfer of records

Patient Name: _____ **Date of Birth:** _____

Patient Social Security Number: _____

Address: _____

City:_____ **State:** _____ **Zip Code:** _____

Patient Phone #: _____ **Patient Cell #:** _____

Patient Work #: _____ **Patient Email:** _____

_____

Previous Physician Information:

Physician: _____

Address: _____

City: _____ **State:** _____ **Zip Code:** _____

Phone Number: _____ **Fax:** _____

Please forward any and all medical records for the above named patient to:

Allied Healthcare Associates
1500 Shermer Rd. Suite 212
Northbrook, IL 60062
Phone (847) 489-9090 Fax (847) 498-9191

_____ _____

Patient Signature/guardian or personal representative **Today's Date**

_____ _____

Date Request Received **Date Sent**