Joseph P. Gavron M.D.
Rebecca E. Boyce Au.D.

1000 Ravinia Place
Orland Park, IL 60462
Phone: (708) 460-6663 Fax: (708) 460-6693

AUTHORIZATION TO RELEASE HEALTHCARE INFORMATION

Patient's Name: ____________________ Date of Birth: ____________________

Previous Name: ____________________ Social Security #: ____________________

I request and authorize ___Southwest Head and Neck Surgical Associates___ to release healthcare information of the patient named above to:

Name: ____

Address: ____

City: ____________________ State: __________ Zip Code: __________

This request and authorization applies to:

☐ Healthcare information relating to the following treatment, condition, or dates: __________

____

☐ All healthcare information

☐ Other: ____

☐ Yes ☐ No I authorize the release of any medical records and forms regarding drug, alcohol, or mental health treatment to the person(s) listed above.

Fees: There is a flat fee of $10 for paper copies and for electronic copies (fax or email). ☐ Paper ☐ Electronic Payment: __________

____

Mailed to:

____

____

____

____

Fax: ____________________

Email: ____________________

Patient Signature: ____________________ Date Signed: __________

Signature agrees to release of medical records and to the fee(s) listed above.

THIS AUTHORIZATION EXPIRES NINETY DAYS AFTER IT IS SIGNED.