

**Release of Medical Records\***

To: \_\_\_\_\_  
(Doctor / Hospital Name)

Street Address: \_\_\_\_\_

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

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

I hereby authorize the release of my medical records:

\_\_\_\_ All Records      \_\_\_\_ Clinic Notes      \_\_\_\_ Laboratory      \_\_\_\_ X-ray/Radiology

\_\_\_\_ EKG/Stress test      \_\_\_\_ Pathology      \_\_\_\_ Immunization      \_\_\_\_ \_\_\_\_\_  
Specify

from \_\_\_\_/\_\_\_\_/\_\_\_\_ to \_\_\_\_/\_\_\_\_/\_\_\_\_ and request to send it to:  
(Date) (Date)

**Parag B. Thakkar, MD**  
1170 E. Belvidere Rd., Ste. 210  
Grayslake, IL 60030  
Phone: (847) 548-9186  
Fax: (847) 548-1356

Name of Patient: \_\_\_\_\_ Date of birth: \_\_\_\_/\_\_\_\_/\_\_\_\_  
Last First MI mm / dd / yyyy

Signature: \_\_\_\_\_ Date: \_\_\_\_/\_\_\_\_/\_\_\_\_  
Patient or Guardian

\* Complete this form and send to the doctor or hospital to request records send to our office. If you need records to be released from our office please contact us.