

Release of Medical Records**

I hereby authorize the **Parag B. Thakkar, MD**, 1170 E. Belvidere Rd., Ste. 210, Grayslake, IL 60030
to 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 :
(Date) (Date)

To: _____
(Doctor / Hospital Name)

Street Address: _____

City: _____ State: _____ Zip: _____

Phone: _____ Fax: _____

Name of Patient: _____ Date of birth: ____/____/____
Last First MI mm / dd / yyyy

Signature: _____ Date: ____/____/____
Patient or Guardian mm / dd / yyyy

** Complete this entire form and send it to our office if you need records to be released from us. Please call us since there is a record release fee.