



for Integrative Medicine at Northwestern

Record Release Authorization

To: _____
Doctor or Hospital

_____ Address

_____ City, State, Zip

Phone: _____ Fax _____

I hereby authorize and request you to release my medical records to:

500 N. Michigan Avenue, Suite 450
Chicago, IL 60611
Phone: 312.276.1212
Fax: 312.276.1213

I am requesting the complete history records in your possession, concerning my illness and/or treatments during the period from _____ to _____.

To include:

All records

Other _____

Name: _____ Birthdate: _____

Address: _____

Phone: (Day) _____ (Evening) _____

Signature: _____ Date: _____