REHAB ASSOCIATES *of* CHICAGO, S.C.

Desert River Solutions

Authorization for Release of Medical Records

Patient Name_____

Address_____

Phone_____

Date of Birth_____ Last Four of Social Security_____

Requesting From (Old Doctor Name):_____

I authorize Desert River Solutions to SEND medical records to the following and by the following option:

☐ Email Secured downloadable link to email below(Fastest)

OR

☐ Mail Encrypted Thumb Drive to Below Address

Send to(Name):_____

Address_____

City_____State_____Zip_____

Email_____(PRINT LEDGIBLY)

☐ **I do** ☐ **do not** authorize the release of information related to AIDS (Acquired Immunodeficiency Syndrome) or HIV (Human Immunodeficiency Virus) infection, psychiatric care and/or psychological assessment and treatment for alcohol and/or drug abuse.

I authorize the release of an electronic version of my medical records in the possession or control of the above named provider/clinic/hospital; its employees and agents.

_____

_____ _____

Patient/Legal Representative Signature Date

_____

Relationship to Patient

Questions/Concerns: requests@DesertRiverSolutions.com or 480-577-3150/ **Expect 15 Business Days for requests**