RECORDS RELEASE AUTHORITY

TO: ____

____

I, ____ hereby request that
(Patient's name or guardian)
you release to:

CENTER FOR INTEGRAL HEALTH

400 E. 22nd St., Suite F

Lombard, IL 60148

Telephone: (630) 792-9311

a report of my diagnosis, treatment, prognosis and recommendations, as well as other data pertinent to your treatment of me from _____________________ to _____________________.

______________________________	______________________________________
(Date of Request)	(Patient's Signature)
______________________________	______________________________________
(Witness)	(Address)
______________________________	______________________________________
(Date)	(City, State, Zip Code)