

Joseph Brindise, DO
Ankur Chhadia, MD
Howard Freedberg, MD
Adam Goldman, DO
Sumit Jain, MD
Samuel Lake, MD
Shoueb Malik, DPM
Dalip Pelinkovic, MD
Kyle Peterson, DPM



Nicole Ambrogio, PA-C
Anthony Bartkowiak, PA-C
Scott Grosh, PA-C
Elizabeth Hauer, PA-C
Hannah Hutchison, PA-C
Joseph Lange, PA-C
Madison Steele, PA-C
Keith Welker, PA-C

Release of Information

Authorization for release of medical records to: _____

From _____
(Name of facility and complete address or fax number)

hereby authorize and request the following to be sent to the address/fax number listed above.

☐ Copies of my medical records

☐ Copies of my X-rays and/or MRIs

☐ Other: _____

Patient's Full Name: _____ DOB: _____

Patient's Signature: _____ Date: _____

Guardian (if patient is a minor): _____

Witness: _____ Date: _____

Please email your completed request to records@suburbanortho.com or fax to 630-233-7008

BARTLETT
1110 W Schick Road
Bartlett, IL 60103

CHICAGO
2118 S Michigan Avenue
Chicago, IL 60616

ELGIN
1600 N Randall Road
Suite 110
Elgin, IL 60123

SCHAUMBURG
1101 Perimeter Drive
Suite 125
Schaumburg, IL 60173

SUBURBANORTHO.COM
(630) 372-1100
(630) 372-6230 (FAX)

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Authorization for Release of Information (Medical Records)

I hereby authorize Suburban Orthopaedics to release medical information from the records of:

Full Name of Patient: _____ DOB: _____

Patient Street Address: _____

City: _____ State: _____ Zip: _____ Phone: _____

Information to be disclosed (*check all applicable items to be released*):

☐ X-rays, MRIs, and/or other Diagnostic Images on DVD (fee may apply)
Date Range: From _____ To _____

☐ Copies of Medical Records - Date Range: From _____ To _____
☐ On Paper (fee may apply)
☐ On DVD (fee may apply)

Should the records be sent to the address above? ☐ Yes ☐ No - If no, the information may be disclosed to:

Name/ Attention: _____ Fax: _____

Address: _____

City: _____ State: _____ Zip: _____ Phone: _____

• I acknowledge that the information disclosed pursuant to this authorization may be subject to re-disclosure by the recipient and no longer protected by Federal Law.

• I have the right to revoke this authorization by written notice to the Healthcare Provider listed above. I understand that actions taken in reliance on this authorization cannot be reversed, and my revocation will not affect those actions.

This authorization expires on: _____ or upon the following event: _____
(*Info authorization date is specified, this authorization will expire 6 months from the date of signature.*)

Patient's/Guardian's Signature: _____ Date: _____

Guardian (if patient is a minor): _____ Date: _____

Relationship to patient: _____

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