

**AUTHORIZATION TO RELEASE COPIES OF MEDICAL RECORDS**

Date: \_\_\_\_\_

Name: \_\_\_\_\_

Date of Birth: \_\_\_\_\_

Social Security Number: \_\_\_\_\_ - \_\_\_\_\_ - \_\_\_\_\_

I hereby authorize the release of records documenting my personal healthcare to be transferred:

To:

The Knight Center for Integrated Health  
5401 N. Knoxville, Suite 104A  
Peoria, IL 61614

From:

Name \_\_\_\_\_

Address \_\_\_\_\_

or Fax to:

309-692-0184

Fax: \_\_\_\_\_

Please initial below for applicable statements:

- ( ) Complete Transfer of Care effective: \_\_\_\_\_/\_\_\_\_\_/\_\_\_\_\_
- ( ) Review Only by a Consulting Physician
- ( ) Review by Insurance Company (Please List Company) \_\_\_\_\_
- ( ) Other (explain) \_\_\_\_\_
- ( ) Exclude Records pertaining to Mental Health
- ( ) Exclude Records pertaining to HIV

Patient Signature: \_\_\_\_\_

If minor, Parent or Legal Guardian Signature: \_\_\_\_\_