

*Advanced Wellness Center  
1750 Randall Road, Suite 250  
Elgin, IL 60123  
847-695-6262  
847-695-6348(fax)*

**RELEASE OF MEDICAL RECORDS**

I, \_\_\_\_\_, born \_\_\_\_\_ and residing  
at \_\_\_\_\_

give Dr. \_\_\_\_\_ and staff permission to release a copy of my medical records  
to the following:

1. \_\_\_\_\_
2. \_\_\_\_\_
3. \_\_\_\_\_
4. \_\_\_\_\_

\_\_\_\_\_  
Date

\_\_\_\_\_  
Signature of Patient/Legal Guardian