

DRS BEAMER, CARLON & CRAIGEN, S.C.

1011 West Lake Street • Suite 300 • Oak Park, IL 60301

Tel. 708-628-0600 • Fax 708-628-0608

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AUTHORIZATION TO RELEASE MEDICAL RECORDS

I, the undersigned, authorize the physician and/or administrative or clinical staff at
Drs Beamer, Carlon & Craigen, S.C.
1011 West Lake Street, Suite 300 • Oak Park, IL 60301
708-628-0600 (Tel) • 708-628-0608 (Fax)

To use and/or disclose a copy of the specific health and medical information identified below for

Last Name of Patient or Minor Child _____
First Name Middle Initial _____
Date of Birth (Month/Day/Year)

Send records to

Name / Practice Name

Address _____
City State Zip

Phone Number _____
Fax Number

By initialing the spaces below, I specifically authorize the use and/or disclosure of the following health information and/or records if such information and/or records exist:

(initial) Please send the following medical records from _____ to _____
Month/Day/Year Month/Day/Year

(initial) Progress Notes _____
(initial) Laboratory Tests _____
(initial) Diagnostic Imaging

(initial) Consult Notes _____
(initial) Pathology Reports _____
(initial) Billing Statements

(initial) Other, please specify _____

(initial) HIV/AIDS related information and records

(initial) Mental Health information and/or records

(initial) Genetic testing information and/or records

Drug/alcohol diagnosis, treatment or referral information. Federal regulations require a description of how much and what kind of information is to be disclosed.

(initial) **Describe:** _____

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