**Hobson Meadows Family Medicine**

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Records Release Authority Form

Request To (company, office, practitioner, etc.

Request For (dates of treatment, what documents are requested, etc.)

I,\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_(Date of Birth:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_) or a designated party responsible for my health (such as a guardian or caregiver), hereby request that you release records to my primary provider at Hobson Meadows Family Medicine. A report of my Diagnoses, treatment, prognosis and recommendations are to be mailed or faxed by using the contact information granted above.

Patient’s Address

Patient’s Telephone Number

Patient or the responsible parties signature (if responsible party, please indicate relationship)

Date of Request