



Form Completion Request

SECTION A: FOR FRONT DESK /MEDICAL RECORDS PSR TO COMPLETE::

Patient Name: _____ Patient DOB: ____/____/____ Patient Number: _____

NUMBER OF FORMS :

_____ Patient's Form-\$25.00 ea = \$____.00 _____ FMLA-\$25.00 ea = \$____.00

_____ Handicapped Parking Form-Free _____ Disability Form-\$25.00 ea = \$____.00

TOTAL FEE DUE: \$ _____ .00

Note made & forms received by _____ paid via _____ and sent to Medical Records on ____/____/____.

SECTION B: FOR PATIENT/GUARDIAN TO COMPLETE:

I request the above named form completed by _____ and then be:

(Doctor's Name)

Picked up at your Carol Stream/Naperville/Wheaton Office by _____ ,
_____.
(Circle One location) (Name of authorized person) (Relationship)

Faxed to: _____ attn: _____ Fax Number : (____)____-_____
(Company name)

Sent to: _____

I understand it will take 7-10 business days for forms to be completed. I understand that payment for these services via cash, check, or credit card will be necessary before forms can be distributed. I authorize the release of any facts and/or related records concerning the injury, illness, or treatment (including mental/nervous diagnosis/treatment, infectious/contagious disease information, and/or information about drug, alcohol, or substance abuse or treatment of same) of myself or my dependents to the named party as specified above. A photocopy of this authorization shall be considered as effective and valid as the original.

Signature of Patient or Parent/Guardian if patient is under 18 yrs old

Date of Request

SECTION C FOR MEDICAL RECORDS PSR TO COMPLETE:

Forms given to _____ on ____/____/____ Forms returned from Medical Staff on ____/____/____

Called patient on ____/____/____ by _____ Note Made _____ **Total Fee to collect: \$ _____**

Records Faxed/Sent on ____/____/____ by _____

SECTION D: RECORD OF PICK UP

Signature of Patient or Authorized Person

Printed Name

Date of Pick-up

Signature of Witness

Date