



Authorization for Release of Information

I, _____ (Name of Applicant) _____ (Date of Birth)

hereby authorize _____ (Name of Physician, Facility or Hospital)

_____ (Street Address of Above)

_____ (City, State, and Zip Code)

to release copies of my medical records regarding my Admission and Discharge, History and Physical, Treatment Plan, Progress Notes/Orders, Social History, Psychiatric/Psychological Evaluation, or other: _____ for the dates of service from _____ to _____ for the specific purpose of determining admission to Winning Wheels, Inc.

I understand that my authorization shall remain effective for 6 months after date of signature and that all information will be handled confidentially, and that I may inspect and have copies of information being released. I also understand that I may revoke this authorization at any time by written and dated communication.

I have read and fully understand this release. _____ (Date)

(Signature of Applicant)

(Signature of Witness)

(Signature of Guardian)

(Signature of Witness)

Please send records to: Director of Admissions
Winning Wheels, Inc.
701 East Third Street
Prophetstown, IL 61277