RIFE & ASSOCIATES
FAMILY HEALTH CARE

Release for Medical Information

TO: _____
Physician's Name

_____
Address

_____
City State Zip Code

_____
Phone Number Fax Number

I hereby authorize and request the release to:

Dr. Susan Rife Family Healthcare
10755 W. 163rd Place
Orland Park, IL 60467

Phone: 708-873-1187 Fax: 708-364-9307

Please release all documents from date _____ to _____ including:

_____ All Medical Care _____ Laboratory Reports
_____ Radiology Reports _____ Other

Patient's Name _____ DOB _____

Patient's Signature _____ Date _____

Patient's Address _____

Signature of Witness _____