1220 W. Higgins Rd, Suite 102
Hoffman Estates, IL 60169
Ph: 847-755-9393
Fax: 847-755-1560

Date: _____

To: _____

Re: _____

DOB: _____

Please send a copy of my medical records to the address indicated below:

If specific records ae being requested (contact lens prescriptions, LASIK post-op, specific dates of service, etc.) please list them here:

Signed (Patient): _____

A charge will apply to records requested on paper according to Illinois comptroller's office. Fee is waived if records are transferred electronically by fax, e-mail, or patients personal data storage device such as flash drives.