



(217) 224-SPECS (7732) * (217) 214-9437 Fax
195 South 36th Street, Quincy, IL 62301
www.myspecsquincy.com

AUTHORIZATION TO RELEASE HEALTHCARE INFORMATION

Patient's Name: _____ Date of Birth: _____

Previous Name: _____

I request and authorize _____ to
release healthcare information of the patient named above to:

Name: SPECS

Address: 195 South 36th Street

City: Quincy State: IL Zip Code: 62301

This request and authorization applies to:

Healthcare information relating to the following treatment, condition, or dates: _____

All healthcare information

Other: _____

Authorizing Signature: _____ Date Signed: _____

Relationship to Patient: Self Parent Guardian Legal Representative

THIS AUTHORIZATION EXPIRES NINETY DAYS AFTER IT IS SIGNED