4300 N. Brandywine Dr • Peoria, IL 61614 • P 309.692.0123 • F 309.692.0184
info@theknightcenter.com • www.theknightcenter.com

AUTHORIZATION TO RELEASE COPIES OF MEDICAL RECORDS

Date: ______________ Name: ____

Date of Birth: ___/___/_____(MM/DD/YYYY) Social Security Number: _____-___-______
(ok to just give last 4 digits)

I hereby authorize the release of records documenting my personal healthcare to be transferred:

To:

The Knight Center for Integrated Health
Rebecca Knight, MD
Ben Miles, DC
Kerry Maloney, APN
4300 N. Brandywine Dr.
Peoria, IL 61614
or Fax to:
309-692-0184

From:

Name: ___________________________

Address: ______________________________

____

____

Fax: ____________________________

Please initial below for applicable statements:

( ) Complete Transfer of Care effective: ____/_____/_______
( ) Review only by a consulting physician
( ) Other (please explain) ____
( ) INCLUDE records pertaining to MENTAL HEALTH
( ) INCLUDE records pertaining to HIV
( ) INCLUDE records pertaining to GENETIC TESTING

Patient Signature: ____ Date signed: ______________

If minor, Parent or Legal Guardian Signature: ____

If unable to give consent, POA: ____

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