Department of Police - City of Chicago
3510 South Michigan Avenue - Chicago, Illinois 60653

CONSENT BY PATIENT
FOR DISCLOSURE/RELEASE OF MEDICAL INFORMATION

The Undersigned (Name of Patient), _____

Patient's Address _____

who is or has been a patient of organization ("The Organization")_____

Organization's Address _____

hereby consents that the Organization may disclose/release to the Chicago Police Department, or the State's Attorney's Office of Cook County any and all documents concerning the examination, treatment, diagnosis, prognosis, doctor's reports, X-rays, hospital reports and all other records relative to the injury or sexual assault that was sustained on:

(DATE)_____ at or near (Location) _____

for the following purpose (state the purpose or need for the disclosure)

_____
_____
_____

The consent hereby given is subject to revocation at any time, except to the extent that action has been taken in reliance thereon. Patient waives the right to withhold information on alcohol and drug use and the consent hereby given will expire (state date, event or condition upon which the consent will expire without express revocation):

_____
_____
_____

The signature below acknowledges that the above is affirmed and understood

this _____ day of _____,20 ____ at Chicago, Illinois.

If patient is a minor -
Signature of Patient's Parent/Guardian

_____

Patient's Signature

_____

CPD-44.117 (REV. 4/12)