HOSPITAL RELEASE

Medical Section
Human Resources Division
Chicago Police Department

Date:_____

Hospital: _____

Address:_____

City/State/Zip:_____

Officer's Name:_____

Social Security # _____ Employee # _____

Address: _____ Date of Birth: _____

Date of Treatment/Admission: _____

Workman's Comp:_____ NON Workman's Comp: _____

Attention: Medical Records Administrator:

It is imperative that we have the following medical records:

____Emergency Room Report

____History and Physical

____Results of all X-Rays

____All Laboratory Test Results

____Operative and Anesthesiology Reports

____Outpatient Records

____Cardiology Summary/Cardiac Clearance

____Discharge Summary

Please forward these records to Chicago Police Department
Medical Section
3510 S. Michigan Avenue
Chicago, IL 60653 Attn. Case Manager:_____
FAX: 312-745- _____

A copy of this release will serve as valid as the original.
I hereby authorize the above hospital, clinic, or medical facility to release any and all information pertaining to my medical history, examinations, medications, prognosis, and/or copies of my records to the Medical Section.

MEMBER SIGNATURE:_____ Date: _____

WITNESS SIGNATURE:_____ Date:_____
