

**FOX VALLEY ORTHOPAEDIC INSTITUTE / COSPORT PHYSICAL THERAPY**

2525 Kaneville Road, Geneva, IL 60134 630-584-1400 - FAX 630-584-1733  
1975 Lin Lor Lane, Elgin, IL 60123 847-468-1400

**AUTHORIZATION FOR RELEASE OF CONFIDENTIAL INFORMATION**

\_\_\_\_\_\*I, \_\_\_\_\_ hereby authorize Fox Valley Orthopaedic Institute  
(Name of Patient / Guardian / Authorized Person)

\_\_\_\_\_\* I, \_\_\_\_\_ hereby authorize \_\_\_\_\_  
(Name of Patient / Guardian / Authorized Person) (Doctor Name / Facility)

\*to release to: \_\_\_\_\_ (Street Address, City, State, and Zip Code)

\_\_\_\_ Self \_\_\_\_\_ / \_\_\_\_\_ / \_\_\_\_\_  
(Date of Birth) (Street Address, City, State, and Zip Code)

\_\_\_\_ Other \_\_\_\_\_  
(Name of Healthcare Facility / Physician/ Agency, Etc.)  
\_\_\_\_\_  
(Street Address, City, State, and Zip Code)

\_\_\_\_ Fox Valley Orthopaedic Institute, 2525 Kaneville Road, Geneva, IL 60134

**\*the following information contained in the patient record of**

\_\_\_\_ Self  
\_\_\_\_ Other \_\_\_\_\_ / \_\_\_\_\_ / \_\_\_\_\_  
(Name of Patient) (Date of Birth) (Street Address)  
\_\_\_\_\_  
(City, State and Zip Code)

**\*Medical Records to be Released:**

\_\_\_\_ Progress Notes \_\_\_\_\_ X-Ray Reports \_\_\_\_\_ Laboratory Results  
\_\_\_\_ Work/School Status \_\_\_\_\_ Operative Reports \_\_\_\_\_ Physical Therapy Notes  
\_\_\_\_ Entire medical record (excluding mental health treatment, alcoholism treatment, drug abuse treatment, & HIV/AIDS records)  
\_\_\_\_ Other: \_\_\_\_\_

**\*Radiology to be released:**

\_\_\_\_ X-Ray / MRI **CIRCLE ONE:** X-rays on Film - \$10.00 per film On CD / Paper – No Charge Outside Films to be Returned

Films Released: \_\_\_\_\_

**\*The following dates of service shall be released:**

From \_\_\_\_\_ / \_\_\_\_\_ / \_\_\_\_\_ to \_\_\_\_\_ / \_\_\_\_\_ / \_\_\_\_\_.

**\*The purpose of this authorization is:** \_\_\_\_\_

- I understand that I have the right to inspect and copy the information I have authorized to be disclosed by this authorization. In the event I refuse to authorize the release of the above described information, I understand that it will not be disclosed, except as provided by law.
- I understand that the practice may not condition treatment on whether I sign this authorization, except when the provision of health care is solely for the purpose of creating protected health information for disclosure to a third party.
- I understand that information used or disclosed pursuant to this authorization may be subject to redisclosure by the recipient, and may no longer be protected by law.
- I understand that this authorization is valid until it expires, unless revoked before that.
- I understand that I may revoke this authorization at any time by giving written notice to the physician of my desire to do so. I also understand that I will not be able to revoke this authorization in cases where the physician has already relied in it to use or disclose my health information. Written revocation must be sent to the physician's office.

**\*Absent such written revocation, this Authorization for Release of Confidential Health Information will terminate on**

\_\_\_\_\_/\_\_\_\_\_/\_\_\_\_\_. (If no date entered, authorization will expire 1 year from date signed)

**\*Please check appropriate box:**

\_\_\_\_ To be picked up on \_\_\_\_\_ **Circle One:** Gen S / Gen N / Elgin  
\_\_\_\_ To be mailed to my home ID checked \_\_\_\_\_  
\_\_\_\_ To be mailed directly to Healthcare Facility/ Physician/ Agency/Etc. listed above

**\*Phone Number to Call When Ready:**

(\_\_\_\_) \_\_\_\_\_--\_\_\_\_\_

**NOTE: RECORDS CANNOT BE FAXED**

\*Signature : \_\_\_\_\_ Date : \_\_\_\_\_ / \_\_\_\_\_ / \_\_\_\_\_

\* Witness : \_\_\_\_\_ Date: \_\_\_\_\_ / \_\_\_\_\_ / \_\_\_\_\_

**FOR OFFICE USE ONLY**

RECORDS COPIED \_\_\_\_\_ / \_\_\_\_\_ / \_\_\_\_\_ INITIALS \_\_\_\_\_ REC'S FEE \$ \_\_\_\_\_ ACCOUNT# \_\_\_\_\_

FILMS COPIED \_\_\_\_\_ / \_\_\_\_\_ / \_\_\_\_\_ INITIALS \_\_\_\_\_ X-RAY FEE \$ \_\_\_\_\_

RECORDS RELEASED \_\_\_\_\_ / \_\_\_\_\_ / \_\_\_\_\_ INITIALS \_\_\_\_\_ REQUEST TAKEN BY: \_\_\_\_\_ DATE: \_\_\_\_\_