FOX VALLEY ORTHOPEDICS

AUTHORIZATION FOR RELEASE OF PATIENT HEALTH INFORMATION

PATIENT INFORMATION

Patient Name:_____ **Date of Birth:**_____ **Phone:**_(___)_____
First Name Last Name

INFORMATION TO BE RELEASED FROM (select one only)

☐ **Fox Valley Orthopedics** ☐ **Other Facility:**_____

INFORMATION TO BE RELEASED TO (select one only)

☐ **Self** ☐ **Guardian/Authorized Representative** ☐ **Other Facility:** ☐ **Fox Valley Orthopedics**

Name:_____ **Address:**_____

City/State/Zip:_____ **Phone:**_____

PURPOSE OF RELEASE	INFORMATION TO BE RELEASED
☐ **Continued Care** ☐ **Copies for own use** ☐ **Insurance** ☐ **Legal / Attorney** ☐ **Other:**_____ *Record copy fee will be assessed based on the number of pages requested	** **PLEASE FILL IN DATES AND MARK APPROPRIATE BOXES** ** **DATE FROM:** _____ **DATE TO:**_____ ☐ **Office Notes** ☐ **Work / School Status** ☐ **Laboratory Results** ☐ **Other:**_____ ☐ **Operative Reports** ☐ **X-ray/MRI Reports** ☐ **X-ray/MRI Images on CD (1st copy no charge - add'l copies $15 ea.)** **NOTE: WE DO NOT FAX OR E-MAIL RECORDS TO PATIENTS OR ATTORNEYS**

☐ To be picked up in office: —> ☐ **Geneva/Kaneville Rd.** ☐ **Geneva/Soderquist Ct.** ☐ **Elgin/Lin Lor** ☐ **Elgin/Randall Rd.**
OR ☐ **Elgin/Royal** ☐ **Algonquin** ☐ **Barrington** ☐ **Yorkville**

☐ Mailed to my home – address on file **Phone # to call when ready:**

☐ To be mailed directly to facility listed above (_____) _____--_____

☐ Other_____

·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 one year from date signed 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 on it to use or disclose my health information. Written revocation must be sent to the physician's office.

SIGNATURE:_____ **DATE:**_____
(Patient/Guardian/Authorized Representative)

Submit request to one of the following: Mail: (1) Fox Valley Orthopedics
2525 Kaneville Rd.
Geneva, IL 60134
(2) Fax: (630) 584-1733
(3) E-mail: info@fvortho.com
(4) Drop off (see locations above)

****

FOR OFFICE USE ONLY - PLEASE COMPLETE ALL FIELDS Rev 1/26

REQUEST TAKEN BY: NAME:_____ **DATE:**_____ **PATIENT#**_____ **CASE#**_____

DATE RECORDS AND/OR IMAGES COPIED: _____/_____/_____ **NAME:** _____ **FEE $** _____

DESCRIPTION/DATE OF IMAGES: _____

DATE X-RAYS/RECORDS RELEASED _____/_____/_____ ☐ **ID VERIFIED** ☐ **PAYMENT** **NAME** _____