FOX VALLEY ORTHOPEDICS

MAIN OFFICE: **2525 Kaneville Road, Geneva, IL 60134 630-584-1400 - FAX 630-584-1733**
2535 Soderquist Ct., Geneva, IL 60134
1975 Lin Lor Ln., Elgin, IL 60123

AUTHORIZATION FOR RELEASE OF PATIENT HEALTH INFORMATION

PATIENT INFORMATION

Patient Name:_____ **Date of Birth:**_____ **Phone:**_____

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:**_____

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

PURPOSE OF RELEASE	INFORMATION TO BE RELEASED
☐ **Continued Care** ☐ **Copies for own use** ☐ **Insurance** ☐ **Legal / Attorney** ☐ **Other:**_____	**DATE FROM:** _____**(Required)** **TO:**_____**(Required)** ☐ **Office Notes** ☐ **Operative Reports** ☐ **Laboratory Results** ☐ **Work / School Status** ☐ **Physical Therapy Notes** ☐ **Other:**_____ ☐ **Entire medical record (excluding mental health treatment, alcoholism treatment, drug abuse treatment, & HIV/AIDS records) - not including x-ray/MRI records & images** ☐ **X-ray/MRI Reports** ☐ **X-ray/MRI Images on CD (1st copy no charge - add'l copies $15)** ******RECORD COPY FEE WILL BE ASSESSED BASED ON THE NUMBER OF PAGES REQUESTED****** ******************** WE DO NOT FAX OR E-MAIL RECORDS TO PATIENTS ************************

Please check appropriate box: **Phone Number to Call When Ready:**

☐ To be picked up on_____ ☐ Geneva South ☐ Geneva North ☐ Elgin (_____) _____--_____

☐ Mailed to my home – address on file

☐ 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)

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FOR OFFICE USE ONLY Rev 11/20

REQUEST TAKEN BY: _____DATE:_____PATIENT#_____ ACCOUNT#_____

RECORDS COPIED _____/_____/_____ INITIALS _____ REC'S FEE $ _____

X-RAYS/MRI COPIED _____ _____/_____/_____ INITIALS _____

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