Medical Records • 625 Enterprise Drive, Oak Brook, IL 60523
medicalrecords@athletico.com • Phone (630) 280-2812 • FAX (630) 280-2912

AUTHORIZATION FOR RELEASE OF PATIENT HEALTH INFORMATION

Please mail authorization form to the appropriate address listed above

Patient: ____
Last Name First Name MI

Date of Birth: ________________ Phone Number: ________________

I authorize Athletico to disclose my protected health information (PHI) in the manner described below.

Method of Delivery: *(Check one)*

☐ E-Mail address: ________________

☐ I understand communication by email has a number of risks, and there is potential that email sent or received can be intercepted, altered, forwarded and /or read by others.

☐ FAX (fax number): ________________

☐ US Mail To: ________________
Person / Organization

____
Address

____
City State Zip

Dates of Service: *(Check one)* **Clinic:** ________________

☐ Please provide a complete copy of my medical records for all dates of service.

☐ Please provide a copy of my medical records for service from ________ to ________
Date Date

Records to be Released: *(Check one)*

☐ All medical records ☐ Progress Notes ☐ FCE Report
☐ Initial Evaluation ☐ Discharge Summary ☐ Itemized Billing
☐ Daily Notes ☐ Home Exercise Program ☐ Other: ________________

Please Note: release of records will include sensitive information such as mental health, alcohol/substance abuse and HIV/AIDS.
CHECK below if you prefer we do not include information relating to:

☐ Mental Health ☐ Alcohol and/or substance abuse ☐ HIV/AIDS ☐ Other ________________

This authorization will be used for: *(Check one)*

☐ Patient Request ☐ Social Security / Disability ☐ Continuation of Care ☐ Attorney
☐ Insurance ☐ Worker's Compensation ☐ Other *(reason please)* ________________

I understand that I may revoke this authorization in writing to Athletico 625 Enterprise Drive Oak Brook, IL 60523 at any time and will be effective on the date notified except to the extent that action has been taken in reliance upon this authorization.

I understand that my health care will not be affected if I do not sign this form.

I understand unless otherwise revoked, this authorization will expire on the following date or event: ________________
If no date is indicated, authorization will expire one (1) year from the date signed.

I understand that I have the right to review my health information before release. I also understand that I have a right to receive a copy of this authorization.

I understand there may be a cost associated with processing copies of medical records.

________________ ________________
Date Signature Name of Patient or Legally Authorized Representative

____
Printed Name of Patient or Legally Authorized Representative Relationship of Legally Authorized Representative to Patient

RE-DISCLOSURE: *Notice is hereby given to the patient or legal representative signing this Authorization that Athletico cannot guarantee that the Recipient receiving the requested health information will not re-disclose any or all of it to others. Notice is hereby given to the Recipient that laws prohibit the re-disclosure of any health information regarding drug and/or alcohol abuse, HIV and mental health treatment.*

Medical Records use only **Completed by:** ________________ **Date completed:** ________ **Fee $**________ **10/15**