ATHLETICO
PHYSICAL THERAPY

Mail Request To:
Athletico Medical Records • 600 Oakmont Lane, Suite C, Westmont, IL 60559
Email: medicalrecords@athletico.com • Phone (630) 280-2812 • Fax (630)280-2912

MEDICAL RECORDS RELEASE OF INFORMATION AUTHORIZATION FORM

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

****There may be a charge for release of medical records****

Deliver To: _____ **(Person/Organization)**

Check method of delivery:

□ **Mailing Address:** _____

□ **Email Address:** _____ □ **Fax #:** _____

Records to be Released: ***(Check All That Apply)***

□ All Medical Records □ Itemized Billing Statements □ Other: _____

Provide a copy of my medical records for all dates of service or: From: _____ **To:** _____

Note: Release of records will include sensitive information such as mental health, alcohol/substance abuse and HIV/AIDS.

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

□ Patient Request □ Insurance □ Social Security/Disability □ Other: _____
□ Continuation of Care □ Attorney □ Worker's Compensation _____

- 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.
- I understand that I may revoke this authorization in writing to ***Athletico 600 Oakmont Lane, Suite C, Westmont, IL 60559*** 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.

_____
Patient Signature or Legally Authorized Representative Date

_____
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.*

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Medical Records Use Only Completed By: _____ **Date Completed:** _____ **Fee: $** _____ **3/2/18**