



Deliver Request To:
Athletico HIM Department 2122 York Road, Ste.300, Oak Brook, IL 60523
Email: medicalrecords@athletico.com • Phone (630) 280-2812 • Fax (630)280-2912

MEDICAL RECORDS RELEASE OF INFORMATION AUTHORIZATION FORM

Please complete all fields to ensure timely processing

Patient Name: _____ Date of Birth: _____
Address: _____ Phone: _____
City and State: _____ Email: _____

There may be a charge for release of medical records

Who do you want to send records to? _____

How do you want the records delivered?

- Mailing Address: _____
Email Address: _____
Fax #: _____

What kind of records are needed? (Check All That Apply)

- Medical Records Occupational Health Records Itemized Billing Statements Other: _____

What dates of service are needed? Starting: _____ Ending: _____

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

What will these records be used for?

- 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 2122 York Rd. Ste. 300 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.

Patient Signature or Legally Authorized Representative***

Date

Printed Name of Patient Or Legally Authorized Representative***

Relationship of Legally Authorized Representative To Patient

***If signed by someone other than the patient, additional paperwork is needed to confirm legal representation.

RE-DISCLOSURE: Notice is hereby given to the patient or legal representative signing this Authorization that Athletico cannot guarantee that the Recipient of the requested health information will not re-disclose it to others. The Recipient is further advised that federal and state laws may restrict the re-disclosure of certain sensitive types of health information, including substance use disorder treatment records, HIV-related information, and mental health treatment information, and that re-disclosure of these categories may be prohibited without the patient's specific written consent or as otherwise permitted by law