

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: _____ (Individual, including Suffix or Organization)
Address
(required to process): _____

Check method of delivery:

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

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

All Medical Records Occupational Health 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 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

***Letter of legal representation would be needed if authorization is signed by a patient's attorney

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.