FAMILY MEDICINE FOR MCHENRY COUNTY
1095 Pingree Road, Suite 108, Crystal Lake, IL 60014
Fax #-Business 847-658-7755 / Nursing 847-658-6699 / Medical Records 847-658-9922

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AUTHORIZATION TO USE OR DISCLOSE PROTECTED HEALTH INFORMATION
THIS FORM MUST BE COMPLETED IN FULL TO BE VALID

I hereby authorize use or disclosure of the named individual's health information as described below:

PATIENT name Date of birth Social Security number

Address (street, city, state, zip code) Telephone number

I AUTHORIZE THE FOLLOWING:

RELEASE INFORMATION FROM:

Name: _____

Address: _____

City/State/Zip: _____

Phone: _____ Fax: _____

SEND INFORMATION TO:

Name: _____

Address: _____

City/State/Zip: _____

Phone: _____ Fax: _____

The following medical records for the past 2 years are to be released:

_____ Entire medical record, *INCLUDING* mental health treatment, alcoholism treatment, drug abuse treatment, and HIV/acquired immune deficiency syndrome (AIDS) records

*If you do **NOT** want any or all of the following records to be disclosed, please check below accordingly:*

_____ Mental Health Treatment Records
_____ Alcoholism Treatment Records
_____ Drug Abuse Treatment Records
_____ HIV/Acquired Immune Deficiency Syndrome (AIDS) Records

Other records, please specify below:
_____ X-ray Reports
_____ Laboratory Reports
_____ Other: _____

Treatment Dates
(if different from above): _____
Reason for Request: _____
_____

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. *This office will not disclose records we have received to any other facility nor to the patient, unless required by law.*
I understand that this authorization is valid until it expires, 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. Absent such written revocation, this Authorization for Release of Confidential Health Information will terminate on _____ (date).

I do specifically consent to transmission of my MEDICAL RECORDS via fax/secure messaging. **Yes _____ No _____**

Signed: _____ Date: _____

If you are not the patient, please specify your relationship to the patient: _____

Medical Record Copy fees; the rate is set by Senate Bill 721 Public Act 92-228. Amended rates as of 01/01/2013:
Handling fee $25.99, plus postage, plus $0.97 per page for 1-25 pages; $0.65 per page for 26-50; $0.32 per page for 51 pages or more.
Above fees apply only to copies sent to all others than the patient and amounts over 10 pages. The handling fee is waived for records sent to the patient, but all other fees apply. No charge for copies sent to another medical facility.