AUTHORIZATION FORM FOR RELEASE OF CONFIDENTIAL HEALTH INFORMATION

Date: ____________________

Any Patient/Personal Representative who requests records must fill out this form and agree to all the conditions of release.
Release

I, ____ am requesting that the records

of :__________________________ ___________ to be released
(Patient's Name) (DOB)

From: ______________________________ **To:** _________________________________
(Name of Recipient, Health Care Facility, Physician, Agency, etc) (Name of Recipient, Health Care Facility, Physician, Agency, etc)

______________________________ _________________________________

______________________________ _________________________________

for the following purpose(s) : ____

And/or the following medical information as limited to or to include:
____ Information requested on School / Camp Form
____ Lab and/or X-ray Reports
____ Billing Statements
____ Other: ____

I understand that medical records may not in all cases be faxed. I also agree to pay for the records in accordance with the fee schedule set forth by State of Illinois (Public Act 92-228) plus the cost of priority mail with delivery confirmation postage, if applicable.

After the medical records department receives my request, I understand that I will receive a phone call that will inform me of the cost of the records. I also understand that I will have the option to pick up the records to avoid a postage charge.

I also understand that Dr. Koppula, M.D. has up to 30 days to comply with this request. Unless revoked in writing, this authorization will expire in 1 year.

Signature: __________________________________ Date: ____________________

Relationship to the patient: _____________________ Phone:____________________