FOOT AND ANKLE SPECIALISTS
Powered by WEIL FOOT & ANKLE

# AUTHORIZATIONFORRELEASEOFCONFIDENTIALINFORMATION

PatientName: Dateof Birth / /

Address:

City: State: Zip: Phone: ( ) -

## I AUTHORIZE WEIL FOOT & ANKLE INSTITUTE TO RELEASE TO:

Name:

Relationship to Patient:

Address:

City: State: Zip:

## THE FOLLOWING INFORMATION FROM THEABOVE NAMEDPATIENT'S RECORDS:

Pleasecheckthe appropriatebox(es):

- ☐ EntireMedical Record, including X-rays*
- ☐ EntireMedical Record, encludingX-rays*
- ☐ X-rays only(*Our officeusesfilmlessdigitalimaging)
- ☐ LaboratoryReports
- ☐ Other:Approximatedate(s) of treatment:Purpose/Need:
- ☐ OperativeReports
- ☐ MRIImages (CD ONLY)& Report
- ☐ Office VisitNotes

I wouldlike to arrangeforthe transfer ofrecordsby:□ **CD** □ **EMAIL** □ **PAPER**

Pleasecheckthe appropriatebox:

- ☐ **RUSH REQUEST (ADDITIONAL $25 FEE )**
- ☐ **USPS to the delivery address** _____
- ☐ **Email to the following address**_____
- ☐ ***Secure Fax #**_____
- ☐ ***Pick up records at our Mount Prospect location*ONLY*1660 Feehanville Dr. Ste 450, Mount Prospect 60056.**

Recipient'sphone number:(_____)_____-_____

DeliveryAddress:

Address:

City: State: Zip:

*** Please note any records in excess of 100 pages will require delivery by email**.

**Signature (Patient orLegal Guardian):** **Date:** / /

## NOTICE TOPATIENT

*Iunderstandthatthis consentisvalidfor90daysfromthe dateofsignature. IunderstandthatImayrevokethisconsentat anytimebygiving written noticeto the WeilFoot&Ankle Institute's physicianof mychoiceexceptto the extentthatWeil Foot& Ankle Institute hasalreadyactedin relianceon this contract.Iunderstand thatinformationused or disclosedpursuantto thisauthorizationmay be subjectto redisclosurebythe recipient andmay nolonger be protectedbylaw.This authorizationwillautomaticallyexpire whenthe informationrequestedhas been releasedif I have given nopriornoticeas statedabove.IunderstandIhave therighttoreview andobtainthe informationto be disclosed.*

**CHARGES:** Thefollowing chargesapplytorecordscopiedforpersonaluse*,insuranceandattorneys.
***NO CHARGE for patient's first request.**
Pages1—25: $1.05perpage Pages26—50:$0.70perpage
Pages51andup: $0.35perpage X-rays:$10.00 per C.D
MRIs:$10perC.D RUSH FEE: $25

**Werequireaminimumoffivebusinessdaysafterreceiptofsignedreleasetoprocessrequest.**