1660 Feehanville Dr. Ste 450, Mount Prospect, IL 60056
P: (847) 390-7666 F: (847) 390-9345
E:medicalrecords@weil4feet.com

AUTHORIZATION FOR RELEASE OF CONFIDENTIAL INFORMATION

Patient Name: Date of Birth / /

Address:

City: State: Zip: Phone: ( ) -

I AUTHORIZE WEIL FOOT & ANKLE INSTITUTE/CIOX Health TO RELEASE TO:

Name:

Relationship to Patient:

Address:

City: State: Zip:

THE FOLLOWING INFORMATION FROM THE ABOVE-NAMED PATIENT'S RECORDS:

Please check the appropriate box (es):

- ☐ Entire Medical Record, including X-rays*
- ☐ Entire Medical Record, excluding X-rays*
- ☐ X-rays only (Our office uses film less digital imaging)
- ☐ Laboratory Reports
- ☐ Operative Reports
- ☐ MRI Images (CD ONLY) & Report
- ☐ Office Visit Notes

Other: Approximate date(s) of treatment: Purpose/Need:

Please check the appropriate box:

☐ **Secure email to the following address:** _____

I understand that by requesting my medical records via Ciox eDelivery, I must provide a valid email address, either my own or that of my designated recipient. My records will be provided as Adobe PDF files on Ciox's **eDelivery website. I will receive an email from **eDelivery.com** containing instructions for accessing my records. There may be a fee for collecting my records. If so, an invoice will be included with the records.

☐ ***Pick up records at our Mount Prospect location *ONLY* 1660 Feehanville Dr. Ste 450, Mount Prospect 60056**

Recipient's phone number:(_____)_____-_____

Delivery Address:

Address:

City: State: Zip:

Signature (Patient or Legal Guardian): **Date:** / /

NOTICE TO PATIENT

I understand that this consent is valid for 90 days from the date of signature. I understand that I may revoke this consent at any time by giving written notice to the Weil Foot & Ankle Institute's physician of my choice except to the extent that Weil Foot & Ankle Institute has already acted in reliance on this contract. I authorize Weil Foot & Ankle Institute (and all affiliated companies) to disclose my individually identifiable health information as described above, including but not limited to information concerning communicable diseases such as venereal disease, TB, Human Immunodeficiency Virus (HIV) and Acquired Immune Deficiency Syndrome (AIDS), chemical or alcohol dependency, psychological or psychiatric records, laboratory test results, medical history, treatment, or any such related information. I understand that if the recipient authorized to receive the information is not a health plan or health care provider, the released information may no longer be protected by federal and state privacy regulations. This authorization will automatically expire when the information requested has been released if I have given no prior notice as stated above. I understand I have the right to review and obtain the information to be disclosed.

CHARGES: OCR state regulated rates will apply to all medical record requests