Records Release Authorization

Patient Name_____ Date of Birth_____
Street Address_____
City_____ State_____ Zip Code _____
Cell Phone (_____) _____ Home Phone (____) _____

I hereby authorize the release of protected health information to:

( ) Fox Ridge Medical Associates, LLC
3633 Municipal Drive
McHenry, IL 60050

( ) Other Recipient:
_____
_____

Purpose of this request _____

I hereby authorize the release of protected health information from:

_____
_____

This request applies to the following time-period:

( ) From date _____ to date _____
( ) All dates of service

Please disclose the following information:

( ) Immunization records
( ) Most recent annual physical (or "wellness") office visit note with the associated lab results
( ) Most recent EKG ( ) Most recent echo ( ) PFTs ( ) Colonoscopy Report
( ) All records from past 12 months ( ) All records from past 24 months ( ) Entire medical record

I understand that the medical records may include information regarding mental health disorders, substance abuse, HIV status and genetic testing.

I understand that I have the right to inspect and copy the above requested information, and that no protected health information (PHI) may be released without my consent, except as provided by law (see Notice of Privacy Practice). I understand that the practice may not withhold treatment contingent upon signing this authorization. I understand that the sender assumes no liability for accidental disclosure of PHI by the recipient. I understand that I may revoke this authorization at any time by giving written notice. This authorization will expire _____ (one year from the date of signature unless otherwise noted).

Signature of patient (or responsible party) _____

Printed Name_____

Date_____