Provida Family Medicine
18931 W Washington St, Suite 100
Third Lake, IL 60030
Phone: 847-548-2200
Fax: 847-548-2865

# Medical Record Release Authorization

Patient Name_____Maiden Name_____SS#_____

Date of Birth_____Home Phone_____Cell/Work_____

Address_____City/State/Zip_____

Email Address: _____

**A) I hereby authorize records FROM**:

Name_____

Address_____

City/State/Zip_____

Phone#_____Fax#_____

**B) To be released TO:**

Name Provida Family Medicine

Address 18931 W Washington St, Suite 100

City/State/Zip Grayslake/IL/60030

Phone# 847-548-2200 FAX# 847-548-2865
847-986-2286

**C) For the purpose of:**

_____

**D) Records Format:** Records will always be delivered via user friendly CD or secure fax unless notated here:
☐ Please send printed copies via postal mail

Date Range_____to_____

- ☐ Physicians Office Notes
- ☐ Immunizations
- ☐ Operative/Procedure Reports
- ☐ Cardiology/EKG Reports
- ☐ Lab/Path Reports
- ☐ Radiology/XRay/MRI Reports
- ☐ Other _____

I understand that authorizing the disclosure of this health information is voluntary. I can refuse to sign this authorization. I need not sign this form in order assure treatment. I understand that any disclosure of information carries with it the potential for an authorized re-disclosure and the information may not be protected by federal confidentiality rules. If I have questions about disclosure of my health information, I can contact the authorized individual or organization making disclosure.

I understand that the information in my medical record may include information relating to sexually transmitted disease, acquired immunodeficiency syndrome (AIDS), or human immunodeficiency virus (HIV). It may also include information about behavioral or mental health services, and treatment for alcohol and drug abuse.

I understand that I have a right to revoke this authorization at any time. I understand that if I revoke this authorization, I must do so in writing and present my written revocation to the Medical Records Department. I understand that the revocation will not apply to information that has already been released in response to this authorization. I understand that the revocation will not apply to my insurance company when the law provides my insurer with the right to contest a claim under my policy.

**I have read the information provided on this release form and do hereby acknowledge that I am familiar with and fully understand the terms and conditions of this authorization.**

_____ _____****Subject to Fees**
(Date) (Signature of Patient/Parent/Guardian or Authorized Representative)

This authorization will expire one year from the above date unless I specify an expiration date: _____
(Expiration date of authorization)

***PLEASE READ** Fee Information*:* Provida Family Medicine contracts with DataFile Technologies to copy and provide all medical records requested from our office. We reserve the right to charge the fee schedule as set by the State of Illinois: a $24.81 handling fee, $0.47 per page for the first 25 pages, $0.31 per page for pages 26-50, $0.16 per page for pages 51+ and postage will be invoiced to you from DataFile Technologies, LLC with all of the necessary directions to receive your records. By signing this authorization, you are agreeing to pay DataFile Technologies for your records.