Hopedale Medical Arts Physicians' Office

Consent to Release Physician's Medical Records and/or Billing Statements

NOTE: This form is NOT to be used for release of hospital records or hospital billing statements.
To request Hopedale Hospital medical and billing records, please call (309) 449-4284

PLEASE PRINT LEGIBLY

_____ _____
Full Legal Name of Patient ("Requestor") Patient Date of Birth (required)

_____
Maiden Name or Prior Name(s)

_____
Patient Address: Street City State Zip Daytime Phone

Requesting Records FROM: _____ (insert Physician's name(s)) ("PROVIDER")

Please put a check above the appropriate office where patient is generally seen:

_____	_____	_____	_____	_____
Medical Arts Physicians' Office	Atlanta Doctors Office	Delavan Doctors Office	Mackinaw Doctors Office	Manito Doctors Office
107 Tremont St.	108 S.W. Arch St.	115 E. Fourth St.	407 S. Orchard	101 E. Mason St.
PO Box 267	Atlanta, IL 61723	Delavan, IL 61734	Mackinaw, IL 61755	Manito, IL 61546
Hopedale, IL 61747	Phone: (217) 648-5151	Phone: (309) 244-8311	Phone: (309) 359-3711	Phone: (309) 968-6144
Phone: (309) 449-4338	Fax: (217) 648-5900	Fax: (309) 244-8328	Fax: (309) 359-3731	Fax: (309) 968-7484
Fax: (309) 449-4880				

Please Release TO: _____("RECEIVER")
Name

_____
Street City State Zip

_____ _____
Telephone Fax (optional)

Reason for release (please check one):

_____ Consultation with another Physician
_____ Transfer of care to another Physician
_____ Change in Insurance Coverage
_____ Insurance Company Inquiry
_____ Moving from Area
_____ Application for Medicare, Life, Long Term Care Insurance
_____ Attorney's Office Requesting Records for Litigation
_____ Social Security Application (Disability)
_____ For Patient's Personal Use
_____ Other: _____

Specify Dates of Service FROM: _____ TO: _____ (required)

The specific type(s) of information to be disclosed (released) is as indicated (check):

_____ History & Physical (most recent)
_____ Physician Office Notes
_____ Substance Abuse Records
_____ Only Immunizations
_____ Other (specify):_____
_____ Doctor's Billing Statements
_____ Lab Reports (if performed in office)
_____ Correspondence
_____ Developmental or adult disabilities
_____ RX Medication List
_____ Physician Orders

NOTE: The information disclosed may include matters regarding mental health, developmental disability, alcohol or drug abuse, child abuse and neglect, sexual assault, adult disabilities, and infectious diseases, including HIV. However, if you wish to EXCLUDE such information from release, state which information is to be EXCLUDED here: _____

The patient or the patient's authorized representative must read and initial the following statements:

1. I understand that I may ask to view and copy the information described on this form and that this authorization will expire on the following specific date, event, or condition related to the purpose of disclosure: _____. If no date is indicated here, the authorization will expire 6 months from the date signed. I understand that I may revoke this authorization at any time by notifying the PROVIDER in writing, but the revocation will not affect any actions which may have been taken prior to the receipt of the written revocation. I understand 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 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 to assure treatment or payment or my eligibility for benefits.

Initials: _____

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Patient name: _____

2. I hereby authorize the use or disclosure of the patient's individually identifiable health information as described above. I have been made aware that if the RECEIVER re-discloses this information, it may no longer be protected by federal privacy regulations, and that the PROVIDER, Medical Arts Physicians' Office, its owners, directors, physicians, officers, agents and employees are not responsible or liable for any consequences of such re-disclosure.
   Initials: _____

3. I understand that PROVIDER will not be responsible for any charges incurred for the reproduction of medical records by another health care provider or its contractors, as a result of this request. Any charges for complying with THIS request will be directed to the Requestor, patient or his/her responsible party, if not paid in advance. Fee schedule for copies is available upon request.
   Initials: _____

4. For minor child releases ONLY: If patient is a minor child (under age 18), the undersigned states that he/she (Requestor) is either the legally appointed guardian, or is the child's parent, and Requestor has not been denied access to the minor's records in any court proceeding and, to the Requestor's knowledge, is not currently under investigation by DCFS or any law enforcement agency.
   Initials: _____

5. Upon receipt of records, unless previously paid in full or otherwise provided by Federal or State Statutes, Requestor agrees to promptly pay PROVIDER the copying or reproduction fee in accordance with the fee schedule set by Illinois Statute (735 ILCS 5/8-2001, et.seq) as amended.
   Initials: _____

_____
Signature of Patient or Requestor (DO NOT SIGN THIS FORM IF BLANK)

_____ Date: _____
Print Name (and Relationship to Patient if not the Patient)

Witness: _____ Date: _____

NOTE: A valid Health Care Power of Attorney or proof of guardianship must be on file if Requestor is signing on behalf of an adult patient.

Forward this completed authorization for processing to:
Medical Arts Physicians' Records
107 Tremont St.
PO Box 267
Hopedale, IL 61747
(309) 449-4338

NOTICE: THIS AUTHORIZATION IS NOT TO BE USED FOR RE-DISCLOSURES BY LAW.

This authorization does not allow **verbal** sharing of information by Office employees or providers.

Facsimile reproductions of the signature are acceptable.

The term “Medical Arts Physicians” does not refer to a group medical practice. Each specialty physician is an independent contractor who is not employed by Hopedale Medical Complex.