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.

Patient Information:

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

_____ _____
Maiden Name or Prior Name(s) Daytime Phone

Patient Address:

_____
Street Address City State Zip

Requesting Records FROM: _____
Physician or Group Name(s)

Please indicate where patient is normally seen:

☐ Medical Arts Physicians' Office (Hopedale)
☐ Atlanta Medical Arts Physicians' Office
☐ Delavan Medical Arts Physicians' Office
☐ Mackinaw Medical Arts Physicians' Office
☐ Manito Medical Arts Physicians' Office
☐ Tremont Medical Arts Physicians' Office

Release Records TO: _____
Name

_____
Street City State Zip

_____ _____
Telephone Fax (optional)

Reason for Release (optional):

☐ Consultation with another physician
☐ Transfer of care to another physician
☐ Change in insurance or insurance inquiry
☐ Moving from area
☐ Other: _____
☐ Application for Medicare, Life Insurance, Long Term Care Insurance
☐ Attorney office requesting records for litigation
☐ Social Security Administration (Disability)
☐ Patient's personal use

Dates of Service Requested: _____ → _____
FROM TO

Specific Types of Information to be Disclosed:

☐ Dictated Reports (incl. Office Notes)
☐ Lab Reports (if performed in office)
☐ Diagnostic Testing Reports
☐ Immunization Records (if available)
☐ Complete Medical Record
☐ Doctor's Office Billing Statements
☐ RX Medication List
☐ Correspondence
☐ Other: _____

∗ **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 below:

_____

Signed Authorization: _____
Signature of Patient or Requestor (DO NOT SIGN IF FORM IS BLANK)

_____ _____
Print Name (and if applicable–Relationship to Patient; e.g. POA/Guardian) Date

_____ _____
Witness Date

☐ *If you are a legal guardian or are requesting as the patient's Healthcare Power Of Attorney please check this box*

***A valid Health Care Power of Attorney or proof of guardianship must be on file if Requestor is signing on behalf of the patient.*

***For more information on our confidentiality and disclosure statements, or how to submit this request, please see page 2 of this form.*

Patient or Patient's Authorized Representative Must Read 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 2 years from the date signed. I understand that I may revoke this authorization at any time by notifying the PHYSICIAN (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 of benefits.

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 Physicians who practice at the medical arts physician office, their owners, agents, employees and assigns, or satellite doctors' offices, are not responsible or liable for any consequences of such re-disclosure.

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. Digital copies are charged a flat rate of $35 and paper copies are charged per page.

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.

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.

Forward this completed authorization for processing to:

Medical Arts Physicians' Office
Medical Records Department (HMC)
107 Tremont St.
PO Box 267
Hopedale, IL 61747

P: (309) 449-4286
F: (309) 449-4087

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.