



FOX VALLEY ORTHOPEDICS

AUTHORIZATION FOR RELEASE OF PATIENT HEALTH INFORMATION

PATIENT INFORMATION

Patient Name: _____ Date of Birth: _____ Phone: (____) _____
First Name Last Name

INFORMATION TO BE RELEASED FROM (select one only)

☐ Fox Valley Orthopedics ☐ Other Facility: _____

INFORMATION TO BE RELEASED TO (select one only)

☐ Self ☐ Guardian/Authorized Representative ☐ Other Facility: ☐ Fox Valley Orthopedics

Name: _____ Address: _____

City/State/Zip: _____ Phone: _____

PURPOSE OF RELEASE

- ☐ Continued Care
☐ Copies for own use
☐ Insurance
☐ Legal / Attorney
☐ Other: _____

*Record copy fee will be assessed based on the number of pages requested

INFORMATION TO BE RELEASED

**** PLEASE FILL IN DATES AND MARK APPROPRIATE BOXES ****

DATE FROM: _____ DATE TO: _____
☐ Office Notes ☐ Work / School Status
☐ Laboratory Results ☐ Other: _____
☐ Operative Reports
☐ X-ray/MRI Reports ☐ X-ray/MRI Images on CD (1st copy no charge - add'l copies \$15 ea.)

NOTE: WE DO NOT FAX OR E-MAIL RECORDS TO PATIENTS OR ATTORNEYS

☐ To be picked up in office: —> ☐ Geneva/Kaneville Rd. ☐ Geneva/Soderquist Ct. ☐ Elgin/Randall Rd.
OR ☐ Elgin/Royal ☐ Algonquin ☐ Barrington ☐ Yorkville

☐ Mailed to my home – address on file
☐ To be mailed directly to facility listed above
☐ Other _____

Phone # to call when ready:

(____) ____ -- ____

I understand that I have the right to inspect and copy the information I have authorized to be disclosed by this authorization. In the event I refuse to authorize the release of the above described information, I understand that it will not be disclosed, except as provided by law.

I understand that the practice may not condition treatment on whether I sign this authorization, except when the provision of health care is solely for the purpose of creating protected health information for disclosure to a third party.

I understand that information used or disclosed pursuant to this authorization may be subject to redisclosure by the recipient, and may no longer be protected by law.

I understand that this authorization is valid one year from date signed unless revoked before that.

I understand that I may revoke this authorization at any time by giving written notice to the physician of my desire to do so. I also understand that I will not be able to revoke this authorization in cases where the physician has already relied on it to use or disclose my health information. Written revocation must be sent to the physician's office.

SIGNATURE: _____ DATE: _____
(Patient/Guardian/Authorized Representative)

Submit request to one of the following: Mail: (1) Fox Valley Orthopedics (2) Fax: (630) 584-1733
2525 Kaneville Rd. (3) E-mail: info@fvortho.com
Geneva, IL 60134 (4) Drop off (see locations above)

FOR OFFICE USE ONLY - PLEASE COMPLETE ALL FIELDS

Rev 1/26

REQUEST TAKEN BY: NAME: _____ DATE: _____ PATIENT# _____ CASE# _____

DATE RECORDS AND/OR IMAGES COPIED: ____/____/____ NAME: _____ FEE \$ _____

DESCRIPTION/DATE OF IMAGES: _____

DATE X-RAYS/RECORDS RELEASED ____/____/____ ☐ ID VERIFIED ☐ PAYMENT NAME _____