Orland Primary Care Specialists

16660 S. 107th Ave., Orland Park, IL 60467
708/403-8500 Fax 708/364-7080

Authorization for Release of Patient Health Information

PATIENT INFORMATION:

Last Name:_____ **First Name:**_____ **Date of Birth:** _____/_____/_____

Address:_____ **City:**_____ **State:**_____ **Zip:**_____

Telephone (Home):_____ **Telephone (Cell):**_____

Information Released From:

Information Released To:

Reason for Requesting Records/Transferring: ***(check all that apply)***

_____ **Geographical Change**

_____ **Insurance Change**

_____ **Referred to Specialist by OPCS**

_____ **Dissatisfied with Doctor, Practice, or Other**
(Please Circle One)

_____ **Legal Purposes**

_____ **Other**
Please specify: _____

Records to be released: ***(Check all that apply and complete time period. If other, use appropriate space on right)***

Other: ***(Please specify on each line below)***

_____**Entire Medical Record**

_____ **Progress Notes** **from**_____ **to**_____
_____ **Lab Reports** **from**_____ **to**_____
_____ **Radiology Reports** **from**_____ **to**_____
_____ **Diagnostic Tests** **from**_____ **to**_____
_____ **Consultation Reports** **from**_____ **to**_____
_____ **Immunization Record** **from**_____ **to**_____
_____ **Itemized Bill** **from**_____ **to**_____

Please note: Orland Primary Care Specialists will only release information generated by our facility. All records that were not originated by our office (transferred records from a previous physician) will not be included in this request. Our office will call you to pick up any records from a previous physician's office once we have scanned them into your electronic medical record. Please keep this in mind if transferring into our facility.

I understand the medical records and information I'm requesting are confidential and cannot be disclosed without my written authorization, except when otherwise permitted by law. Once the above information is disclosed, I understand that it may be re-disclosed by the recipient and may not be protected by federal privacy laws or regulations. I understand this consent may include information in the medical record relating to behavior or mental health, alcohol and/or drug abuse, Acquired Immunodeficiency Syndrome ("AIDS"), or Human Immunodeficiency Virus ("HIV"), or any such related information.

I understand that this authorization is voluntary and I may refuse to sign this authorization. It's subject to revocation/withdrawal by me at any time in writing to the Business Manager. I understand that the revocation will not apply to information that has already been released in response to this authorization. Unless I specify differently, this authorization will expire in three months from the date signed below.

I understand Orland Primary Care Specialists may charge a processing fee for this service.

I acknowledge I have read this authorization and I further acknowledge the above listed information I have provided to be true and correct.

_____ **Signature of Patient or Guardian**

_____ **Printed Name of Patient or Guardian**

_____ **Date**