# Release of Medical Record Authorization

Patient's Name_____ Date of Birth: _____
Previous Name (if any):_____ Daytime Telephone: _____
I request and authorize Zaparackas and Knepper, LTD., to release the records for the patient indicated above. **Please release records to the following organization, or person**:

Name:_____
Address:_____ Suite #_____
City/State:_____
Contact Numbers: Office: _____Fax: _____

Type of records requested: (charges for copies of records may be associated with your request):
_____ All Health care information
_____ Records pertaining to specific treatment of condition: _____
_____ Sensitive Health Information including treatment and diagnosis of mental illness, drug and/or alcohol abuse, sexually transmitted infections and diseases including HIV/AIDS.

Purpose of release of medical information: Continuing Care Personal Use Other: _____

If you are requesting copies of your medical records for your own use, the State of Illinois has established the following fees: $27.91 handling fee per complete record requested; $0.97 per page for pages 1-25; $0.75 per page for pages 26-50; $0.50 per page for pages 50+. I understand that I have the right to revoke this authorization at any time, for any reason, and that I must provide the revocation in writing. I understand that a revocation is not effective when Zaparackas and Knepper, LTD., has already relied on the use or disclosure of the health information or if my authorization was obtained as a condition of obtaining insurance coverage and in the insurer has a legal right to contest a claim. I understand that information used or disclosed pursuant to this authorization may be disclosed by the recipient and may no longer be protected by federal or state laws. I acknowledge that I have fully reviewed and understand the contents of this authorization. I also understand that prior medical records may be re-disclosed to the requested organization or individual. My signature below indicates that I hereby agree and authorize the release of patient health information to the above named.

Signature of patient or responsible party: _____
Printed name:_____
Date: _____

THIS AUTHORIZATION EXPIRES 120 DAYS AFTER DATE SIGNED

For Office Use Only:
Received _____ (date) _____ (staff initials)
Completed _____(date) _____ (staff initials) Physician _____