First Step Foot Care 385 W. Liberty Street Wauconda, IL 60084 Phone: 847.487.2827 Fax: 847.487.2860 Authorization To Release Copies of Medical Records		For Clinic Use Only Date Received _____ Date Processed: _____ Processed By: _____ Account Number: _____

This Authorization is voluntary. I understand that First Step Foot Care will not base treatment, payment, enrollment, or eligibility of benefits on my signing this document. Please see the second page for the fee notice.

Patient Name:	Date Of Birth:
Address:	
Home Phone:	Cell Phone:
Social Security:	Driver's License Number:

I am requesting my following health information: ☐ Entire Medical Record ☐ Radiographic Images (XRAY)

Dates of Service: From: _____ To: _____

Reason for Disclosure:

☐ Continuation of Care / Transfer of Care
☐ Attorney / Legal
☐ Insurance Company
☐ Workman's Compensation
☐ Other (Please specify) _____

Please describe the purpose(s) or need for which the information is to be used by individual / to whom information is to be released

I authorize First Step Foot Care to release my medical records, with no limitations, to the following:

☐ Physician's Office ☐ Family Member ☐ Attorney's Office ☐ Myself

Name of Recipient:	Relationship to Patient:
Address:	
Phone Number:	Fax:

Select Delivery Method: ☐ Pick Up ☐ US Mail ☐ Fax them to _____

Authorization:
I certify that this request has been made freely, voluntarily and without coercion and that the information given above is accurate and complete to the best of my knowledge. I understand that I will receive a copy of this form after I sign it. I may revoke this authorization, in writing, at any time except to the extent that action has already been taken to comply with it. Written revocation is effective upon receipt by First Step Foot Care.

Redisclosure of my medical records by those receiving the above authorized information may be accomplished without my further written authorization and may no longer be protected. Once information is disclosed, First Step Foot Care can no longer protect it from further disclosure.

Without my express revocation, I understand that this consent will automatically expire in one year from the date signed except to the extent that the action has been taken in reliance thereon.

Patient name:	Name of legal representative of patient:
Signature:	Date:

Additional Information Regarding Your Request

Requesting Medical Records on Behalf of Another Person

If you are requesting medical records for someone other than yourself, you may be required to provide additional documentation to show that you have a legal right to request the record set. Examples of these documents include letters of representation, Guardianship Papers, Affidavit of Heir at law, etc. First Step Foot Care reserves the right to ask for a valid driver's license to ensure the protection of all protected health information. Please contact First Step Foot care to determine the documentation that will be required to process your request.

Submitting Requests for Medical Records may be:

- Mailed to First Step Foot Care at 385 W. Liberty Street, Wauconda IL, 60084
- Faxed to First Step Foot Care at 847.487.2860
- Submitted in person to one of our locations. Please call to confirm hours of operation at 847.487.2827. Office hours vary by physician and staff availability.

The Processing of Your Record Request:

Our average turnaround time for processing requests is 10 business days. Unless otherwise requested, records will be sent through the US Mail. Records needed for medical emergencies will be faxed directly to a physician or medical facility. Please include your preferred phone number on your request, in case we need to contact you for additional information. Please contact our office for questions regarding your medical record request.

Fees:

Fees are authorized annually by the State of Illinois. Under Illinois law Code of Civil Procedure 735 ILCS 5/8-2001(d) the amount a physician or other health care provider may charge for copying medical records is limited. If your request requires pre-payment, a fee notice can be requested upon processing your request for records. For 2015 rates for records are as follows:

Fee	2015
Handling Charge for Medical Records	$26.58
Handling Charge for Radiographic Images (XRAYs)	$10.00
Copy pages 1 through 25	$1.00
Copy pages 26 through 50	$0.66
Copy pages in excess of 50	$0.33