GENERAL MEDICAL RECORDS RELEASE AND AUTHORIZATION FOR USE OR DISCLOSURE OF PROTECTED HEALTH INFORMATION

Requested by ______________________________ Tel ______________________

Address ____

I authorize the custodian of records of (**patient name**)______________________________

Patient date of birth ________________ to disclose/release the following information:

- ☐ Medical records
- ☐ Laboratory test results
- ☐ Radiologic test results
- ☐ Counseling records
- ☐ Specific record ______________________________

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*Medical records from previous doctors or records older than 2 years **will not** be included in this release unless they are specifically relevant to the management of a current condition.

**AIH does not include records from outside offices/providers. However, if there is relevant information in your records that is from an outside source, including information about HIV/AIDS status, cancer diagnosis, drug/alcohol abuse, or sexually transmitted disease, you are authorizing disclosure of this information.

These records are for services provided on the following dates ______________________________

To release information FROM:	**To release information TO:**
Advanced Integrative Healthcare	______________________________
245 S. Gary Ave. Suite 207	______________________________
Bloomingdale, IL 60108	______________________________
Fax: 630-893-5665	Fax: ______________________________

Initial copy of chart notes and test results – free at time of service

$5.00 FLAT FEE FOR THE REQUEST OF UP TO 5 PAGES

Medical records copying fees	$24.42	________
Per Illinois law (public act 92-228)	$0.92 ea page 1-25	________
	$0.61 ea page 26-50	________
	$0.31 ea page 51 on	________
	plus actual postage	________
	Total charges	________

I understand that after the custodian of records discloses my health information, it may no longer be protected by federal privacy laws. I further understand that this authorization is voluntary and that I may refuse to sign this authorization. My refusal to sign will not affect my ability to obtain treatment; receive payment; or eligibility for benefits unless allowed by law. By signing below I represent and warrant that I have authority to sign this document and authorize the use or disclosure of protected health information and that there are no claims or orders pending or in effect that would prohibit, limit, or otherwise restrict my ability to authorize the use or disclosure of this protected health information.

Patient (or representative) signature ______________________________ Date ____________