



Sterling Rock Falls Clinic, Ltd.

A TRADITION OF EXCELLENCE IN THE SAUK VALLEY
101 East Miller Road, Sterling, IL 61081
(815)625-4790

Date to be picked up _____

Appointment Date _____

Today's Date _____

Initials _____ Chart # _____

AUTHORIZATION TO RELEASE MEDICAL INFORMATION

Name of Patient (please print) Social Security Number

Street City State Zip

Date of Birth Phone Spouse's name Maiden Name / or parent's name if minor

I Hereby Authorize:

To Release to:

Name

Name

Address

Address

City, State, Zip

City, State, Zip

Phone # Fax #

Phone # Fax #

What information is being requested?

- ____ Complete SRFC Records
- ____ Doctor's Records (One Physician)
- ____ Laboratory Reports
- ____ X-Ray Reports
- ____ X-Ray Films

- ____ Immunization Records
- ____ Other (Specify) _____
- _____
- _____

This information is being disclosed for the following purpose(s):

- ____ 2nd Opinion – Referred by _____
- ____ Referral – Referred by _____
- ____ Moving
- ____ Seasonal Moving
- ____ Other (Comment if Applicable) _____

1. This authorization shall be in force and effect until _____ at which time this authorization to use or disclose this protected health information expires. If I fail to specify an expiration date, event, or condition, this authorization will expire one year from the date of signing.
2. I understand that I have the right to revoke this authorization, in writing, at any time by sending such written notification to the practice's Privacy Officer at 101 East Miller Road Sterling, IL 61081. I understand that a revocation is not effective to the extent that my physician has relied on the use or disclosure of the protected health information or if my authorization was obtained as a condition of obtaining insurance coverage and the insurer has a legal right to contest a claim.
3. 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 law.
4. My physician will not condition my treatment, payment, enrollment in a health plan or eligibility for benefits (if applicable) on whether I provide authorization for the requested use or disclosure except: 1) if my treatment is related to research, or, 2) health care services are provided to me solely for the purposes of creating protected health information for disclosure to a third party.
5. I consent to the use of a fax machine to transmit any or all of my above described medical records either to or from SRFC. I acknowledge that faxing my medical records may increase the risk of accidental disclosure of my medical records to unauthorized parties. I hereby release the medical care provider faxing the records from SRFC from all legal responsibility for liability that may arise from the act I have authorized herein. The sender of the medical records will not be responsible for the completeness, legibility or omittance caused by the copying and/or faxing of any of the above medical records (including my records from the SRFC or from another institution which may be in the SRFC chart).
6. I authorize _____ to pick up these records. _____ (Patient's Initials)

SIGNATURE

(RELATIONSHIP TO PATIENT)

DATE

SPECIFIC AUTHORIZATION

I acknowledge that data to be released may include material that is applicable to mental health, developmental disabilities, alcohol or drug abuse, and/or sexually transmitted disease information. My signature authorizes release of all such information (as specified above). If I refuse to sign this authorization, those in possession of my medical records will not release them, absent of a court order.

SIGNATURE

WITNESS

DATE

Illinois law allows for the following charges, per Public Act 92-228:

(Note: a 2-sided page counts as 2 pages)

75 cents per page fee (for pages 1-25) _____ x \$0.89 = _____

50 cents per page fee (for pages 26-50) _____ x \$0.59 = _____

25 cents per page fee (for pages 51+) _____ x \$0.30 = _____

Total Due _____