Orchard Medical Center, S.C. Authorization to Release Health Information
543 Orchard Street, Antioch, IL 60002 Phone: 847-395-3322, Fax: 847-395-0921
Attn: Diane in Medical Records Department

Age of Patient:_____
Patient's Name:_____Date of Birth:_____

Contact Number:_____Social Security No#_____

I request and authorize Orchard Medical Center, S.C. to release or receive (circle either the word "release" or "receive") healthcare information on the patient names above to:

Name:_____

Attn:_____ _____in Medical Records Dept.

Address:_____

City:_____State:_____Zip Code:_____

Phone: _____ Fax _____

This request and authorization applies to:
Healthcare information relating to the following treatment, condition, or dates:_____
_____

ALL Healthcare Information Other:_____

YES NO The following highly confidential records require authorization to release to the person(s) listed above: pregnancy, birth control, sexual assault/abuse, child abuse and neglect, STD results, HIV/AIDs testing, genetics whether positive or negative. I understand that the person(s) listed above will be notified that I must give specific written permission before disclosure of these test results to anyone. *The patient 12 and older must authorize this release*.

YES NO The following highly confidential records require authorization to release to the person(s) listed above: drug, alcohol, or behavioral/mental health treatment or referral information (to include ADD or ADHD). I understand that the person(s) listed above will be notified that I must give specific written permission before disclosure of these test results to anyone. *The patient 12 and older must authorize this release*.

2018 Copying Fees – (www.ioc.state.il.us)

Handling Charge	$27.91
Copy pages 1 – 25	$1.05
Copy pages 26-50	$0.70
Copy pages in excess of 50	$0.35
Copies made from microfiche or microfilm	$1.74
Postage:_____	
Total:_____	

Pick Up Records: YES NO Mail Records PLUS Postage: YES NO

Designated/Authorized Individual to Pick Up Copied Records:_____
(The above named person is required to present a picture ID (state ID or valid Driver's License) to our staff before forms are to be released)

Reason for leaving practice:_____

Please allow up to 14 business days to process your request

I understand by signing below I have the right to inspect or copy the records that are being released. I agree to sign this authorization and understand I will be given a copy once I have signed. I also understand I will need to submit a written letter of cancellation to the Medical Records Department if I choose to cancel this authorization.

Patient Signature:_____Date Signed:_____
Patient Printed Name:_____
Parent/Guardian Signature:_____Date Signed:_____