Pedios, Ltd
260 Chicago Ave
Oak Park, IL 60302
708-383-8070
Fax# 708-383-0811

AUTHORIZATION TO RELEASE MEDICAL RECORDS

I authorize the physician and/or administrative and clinical staff at:

_____

Physician or Practice Name

_____

Address

_____

Phone number **Fax number**

To use and/or disclose a copy of health and medical information for:

_____

Patient Last Name **First Name** **Date of Birth**

Release or send records to:

_____

Name

_____

Address **City** **State** **Zip Code**

_____

Phone Number **Fax Number**

I understand that, if the person or entity receiving this information is not a healthcare provider or health plan covered by federal privacy regulations, the information described above may be re-disclosed and no longer protected by these regulations.

I understand that I have the right to revoke or terminate this authorization, in writing, at any time by sending such witten notification to Pedios, Ltd. unless revoked earlier, this authorization will expire 1 year from the date of signing.

The fee for copying/releasing medical records is between $15.00-25.00 for each photocopied chart.

_____

Print Name of patient or Patient Representative **Signature of Patient or Patient Representative**

_____

Relationship to Patient **Date**