



FOOT & ANKLE INSTITUTE

1660 Feehanville Dr. Ste 450, Mount Prospect, IL 60056

P: (847) 390-7666 F: (847) 390-9345

[E:medicalrecords@weil4feet.com](mailto:medicalrecords@weil4feet.com)

AUTHORIZATION FOR RELEASE OF CONFIDENTIAL INFORMATION

Patient Name: _____ Date of Birth: ____/____/____
Address: _____
City: _____ State: _____ Zip: _____ Phone: (____) ____-____

I AUTHORIZE WEIL FOOT & ANKLE INSTITUTE TO RELEASE TO:

Name: _____
Relationship to Patient: _____
Address: _____
City: _____ State: _____ Zip: _____

THE FOLLOWING INFORMATION FROM THE ABOVE NAMED PATIENT'S RECORDS:

Please check the appropriate box(es):

- | | |
|--|--|
| <input type="checkbox"/> Entire Medical Record, including X-rays* | <input type="checkbox"/> Operative Reports |
| <input type="checkbox"/> Entire Medical Record, including X-rays* | <input type="checkbox"/> MRI Images (CD ONLY) & Report |
| <input type="checkbox"/> X-rays only (*Our office uses filmless digital imaging) | <input type="checkbox"/> Office Visit Notes |
| <input type="checkbox"/> Laboratory Reports | |
| <input type="checkbox"/> Other: Approximate date(s) of treatment: Purpose/Need: | |

I would like to arrange for the transfer of records by: CD EMAIL PAPER

Please check the appropriate box:

- RUSH REQUEST (ADDITIONAL \$25 FEE)
- USPS to the delivery address _____
- Email to the following address _____
- *Secure Fax # _____
- *Pick up records at our Mount Prospect location ***ONLY*** 1660 Feehanville Dr. Ste 450, Mount Prospect 60056.

Recipient's phone number: (____) ____-____

Delivery Address: _____
Address: _____
City: _____ State: _____ Zip: _____

* Please note any records in excess of 100 pages will require delivery by email.

Signature (Patient or Legal Guardian): _____ Date: ____/____/____

NOTICE TO PATIENT

I understand that this consent is valid for 90 days from the date of signature. I understand that I may revoke this consent at any time by giving written notice to the Weil Foot & Ankle Institute's physician of my choice except to the extent that Weil Foot & Ankle Institute has already acted in reliance on this contract. I understand that information used or disclosed pursuant to this authorization may be subject to redisclosure by the recipient and may no longer be protected by law. This authorization will automatically expire when the information requested has been released if I have given no prior notice as stated above. I understand I have the right to review and obtain the information to be disclosed.

CHARGES: The following charges apply to records copied for personal use*, insurance and attorneys.

***NO CHARGE for patient's first request.**

Pages 1—25: \$1.05 per page	Pages 26—50: \$0.70 per page
Pages 51 and up: \$0.35 per page	X-rays: \$10.00 per C.D
MRI's: \$10 per C.D	RUSH FEE: \$25

We require a minimum of five business days after receipt of signed release to process request.