

# AUTHORIZATION FORM FOR RELEASE OF CONFIDENTIAL HEALTH INFORMATION

**DIANE L. OZOG, M.D., S.C.**

1288 Rickert Drive - Suite 100 Naperville, Illinois 60540

Phone: 630-652-0606

Fax: 630-652-9900

Date: \_\_\_\_\_

Any Patient/Personal Representative who requests records must fill out this form and agree to all the conditions of release.

Release

I, \_\_\_\_\_ am requesting that the records

of : \_\_\_\_\_ to be released

(Patient's Name)

(DOB)

**From:** \_\_\_\_\_ **To:** \_\_\_\_\_  
(Name of Recipient, Health Care Facility, Physician, Agency, etc) (Name of Recipient, Health Care Facility, Physician, Agency, etc)

\_\_\_\_\_  
\_\_\_\_\_

for the following purpose(s) : \_\_\_\_\_

And/or the following medical information as limited to or to include:

\_\_\_\_ Information requested on School / Camp Form

\_\_\_\_ Lab and/or X-ray Reports

\_\_\_\_ Billing Statements

\_\_\_\_ Other: \_\_\_\_\_

I understand that medical records may not in all cases be faxed. I also agree to pay for the records in accordance with the fee schedule set forth by State of Illinois (Public Act 92-228) plus the cost of priority mail with delivery confirmation postage, if applicable.

After the medical records department receives my request, I understand that I will receive a phone call that will inform me of the cost of the records. I also understand that I will have the option to pick up the records to avoid a postage charge.

I also understand that Diane L Ozog, MDSC has up to 30 days to comply with this request. Unless revoked in writing, this authorization will expire in 1 year.

Signature: \_\_\_\_\_ Date: \_\_\_\_\_

Relationship to the patient: \_\_\_\_\_ Phone: \_\_\_\_\_

A photo ID will be required at time of pick up. We will not release any records without proper identification.