MRO

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BARRINGTON
Orthopedic Specialists

PATIENT REQUEST FOR HEALTH INFORMATION

Name of Patient: _____ **Date of Birth:** _____

Patient Address: _____ Telephone #: _____

City: _____ State: _____ Zip: _____ Last 4 Digits of SSN: _____

I hereby authorize Barrington Orthopedic Specialists to release my protected health care information. I understand that this authorization is voluntary. No individual has coerced me into signing this authorization and I am providing this authorization under my own free will. I understand that once the authorized person or organization receives this information, then federal privacy laws may no longer protect this information.
This authorization is valid until _____, or 90 days from the date signed.

MEDICAL RECORDS ARE BEING REQUESTED FOR THE FOLLOWING PURPOSE:

❒ Physician or Healthcare Facility ❒ Personal ❒ Legal ❒ Other

REQUESTING COPIES OF MEDICAL RECORDS

❒ ONLY last (1) year of records: (NO CHARGE) ***only your first request for records will be complimentary***

❒ Entire Chart for up to (5) years: (10 cents per page)

❒ Only the following records (please explain): _____

REQUESTING COPIES OF RADIOLOGY IMAGES (images will be burned to a CD):

❒ Images from last (1) year (NO CHARGE) ***only your first request for images will be complimentary***

❒ All Images ($10.00 CHARGE)

❒ Specific Images from dates (X-ray, MRI, etc): _____

SEND THE RECORDS VIA (pick one):

I understand that I will receive a phone call when records are ready for pick-up.

❒ **MAIL** ❒ **FAX** ❒ **PICK UP IN OFFICE** ❒ **PATIENT PORTAL**

MAIL (Please provide address)	**FAX** (Please provide fax number)	**PICK UP** in:	**ONLINE PATIENT PORTAL**
		❒ Schaumburg ❒ Elk Grove Village ❒ Bartlett ❒ Buffalo Grove	You MUST get an enrollment token from the receptionist if you are new to the portal!!!

I understand:

- The information in my health record may include information relating to sexually transmitted disease or acquired immunodeficiency syndrome (AIDS). It may also include information about behavioral or mental health services; and treatment for alcohol or drug abuse.
- I have the right of access to inspect and obtain a copy of my protected health information.
- I have the right to revoke this authorization at any time by notifying Barrington Orthopedic Specialists in writing.
- Revocation will not apply to information that has already been released.
- Once this information is disclosed, there is the potential that it may be re-disclosed by the recipient; and therefore may not be protected by the federal privacy regulations.
- I may refuse to sign this authorization. I do not need to sign this form to ensure health care treatment, payment, or eligibility for benefits.
- I understand that I may request to receive a copy of this form after I sign it.
- I understand that I must complete the enrollment process in order to access my records through the secure online Patient Portal.
- I understand processing of medical records is subject to very strict laws that protect my privacy and MRO is processing this request.

_____ _____
Signature of Patient or Personal Representative If Personal Representative, relationship to patient

_____ _____
Date Witness

Last update: November 1, 2016