Foot & Ankle Care Michael A. DeVito DPM Chicago Ridge IL 60415
PH: 708-425-5656
FX: 708-425-6155

AUTHORIZATION FOR RELEASE OF INFORMATION

I hereby authorize **Michael A. DeVito, DPM** to disclose my protected health information as described below. I understand that this authorization is voluntary. I understand that the information disclosed pursuant to this authorization may be subject to disclosure by the recipient and may no longer be protected by federal or state law. I understand that I will receive a copy of this form after I sign it. I understand that I may revoke this authorization at any time by giving notice in writing.

-Pursuant to Illinois Public Act 92-228, the office is allowed to charge the following fees for any protected Health Information requested.

*25.00 for Office Notes

*20.00 for X-Ray(s) *1 set* up to 3 views scanned XEROX copy of X-Ray(s)

-We regret at this time we are unable to duplicate X-ray film and cannot release original films)
-X-ray result/impression/report is embedded in the patient progress note as well

*As a professional courtesy, we can fax protected health information to another physician(s) on our secure dedicated fax line at no charge.
*****Please provide full Provider Name, PHONE & FAX numbers in the space below.

Person/Provider/Facility to receive the information:
(Please include physician name, phone# and fax# if you want this information sent to your doctor or other as requested)

_____

_____

Dates of service to be released: _____

(Requests of "Any & All" cannot be honored legally)

Patient Name: _____
PLEASE PRINT

DOB: _____

This authorization will expire 90 days from the date signed unless otherwise stated below

_____ _____
Signature of patient or patient's representative **Date**