Mokena Foot and Ankle Clinic
19841 Wolf Road
Mokena, IL 60448
PH: 708-479-0790
FAX: 708-479-0792

AUTHORIZATION FOR RELEASE OF INFORMATION

I hereby authorize Phillip D. Narcissi, DPM and/or Johnny C. Rossi, DPM to disclose my protected health information as described below. I understand that this authorization is voluntary and 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 and that I may revoke this authorization at any time by giving notice in writing.

- I understand that I am able to view and retrieve my health information on the patient portal linked on the office website, with an option to print such information, *free of charge.*
- Pursuant to Illinois Public Act 92-228, the office is allowed to charge the following fees for any protected Health information requested outside of the information on the portal:

  *$20.00 – office notes

  *$10.00 – digitally copy of x-rays on CD ROM

  *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 the Full MD name, phone number and fax number.

PATIENT NAME: ____

DOB: __________

DATE OF SERVICE TO BE RELEASED: ____
(request of “Any and All” can not be honored legally)

PERSON/ORGANIZATION TO RECEIVE THE INFORMATION: ________________________________

____

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

____
(Patient or patient representative signature) (Date)

____
(Printed name of patient’s representative - if applicable)

____
(Relationship to patient – if applicable)