Foot & Ankle Centers

Centers for Foot and Ankle Surgery, Ltd

Medical Records Release for Patients of Dr. Paul Bishop, DPM, FACFAS

Records Provided by Foot & Ankle Centers

I hereby request that **Foot and Ankle Centers** provide me a copy of my protected health information as described below. I understand that Foot and Ankle Centers has 30 days to comply with my request. In the event they do not, they must provide a written statement to me with the reason for the delay and they must comply no later than 60 days after receiving this request from me. I also understand that there is a reasonable fee associated with this request per Illinois Public Act 093-0087 - https://www.ilga.gov/legislation/publicacts/fulltext.asp?Name=093-0087. Fees are as follows:

- **Handling Fee:** $20.00
- **Copy pages 1 through 25:** $.75 per page
- **Copy pages 26 through 50:** $.50 per page
- **Copy pages in excess of 50:** $.25 per page
- **Digital X-ray Disc**: $5.00
- **Shipping:** Actual cost (if applicable)

PAYMENT IS DUE AT TIME OF REQUEST. OUR STAFF WILL CONTACT YOU WITH AN ESTIMATE.

Patient Full Legal Name: _____ Date of birth: _____

Patient Phone #: _____

At my request, I want a copy of my COMPLETE medical record:

- ☐ **Email : _____ (via secure email, may require UN and PW set-up)**
- ☐ **Hold for pick-up in Morris**
- ☐ **Hold for pick-up in Yorkville**
- ☐ **Mail US Postal Service (actual mailing costs will be applied)**

**** Labs, radiology reports not ordered by Dr. Bishop will not be provided.**

SPECIFIC AUTHORIZATION

I understand my health information to be released MAY INCLUDE information related to sexually transmitted disease, acquired immunodeficiency syndrome (AIDS), or human immunodeficiency virus (HIV), behavioral or mental health services, and/or treatment for alcohol and/or drug abuse. My signature below authorizes release of all such information, **unless I have crossed it out and initialed it.**

Signature (patient/patient's representative):_____ Date:_____

(Form MUST be completed before signing.)

Printed name of patient's representative (if applicable):_____

Relationship to patient (if applicable):_____

YOU WILL RECEIVE A COPY OF THIS DOCUMENT ALONG WITH AN INVOICE FOR THE COPYING OF YOUR MEDICAL RECORDS.

654 W. Veteran's Parkway; Suite D
Yorkville, IL 60560
Ph#: 630-553-9300 / Fax#: 630-553-9306

1802 N. Division; St. Suite 305
Morris, IL 60450
Ph#: 815-942-9050 / Fax#: 815-942-9051