PARKVIEW ORTHOPAEDIC GROUP

For assistance, contact our partner for processing medical records requests, HealthMark Group, at:
Ph: (800) 659-4025
Fax: (800) 833-5935
status@healthmark-group.com

AUTHORIZATION TO OBTAIN OR RELEASE MEDICAL RECORDS

PATIENT INFORMATION

Patient's Name	Maiden/Alias
Address	Date of Birth
Apt/Unit/Suite	Phone
City, ST,ZIP	Email

RELEASE INFORMATION FROM

I authorize the release of information FROM:

Provider/Facility	Parkview Orthopaedic Group, S.C.		
Address	7600 W College Drive	Phone	708-361-0600
City,ST,ZIP	Palos Heights, IL 60463	Fax #	708-361-8710

RELEASE INFORMATION TO

I authorize the release of information TO:

Facility/Company/Person	Phone
Address	Fax #
City,ST,ZIP	Email

DELIVERY METHOD

☐ Electronic Access (preferred) ☐ Fax ☐ Paper-USPS Mail ☐ CD-USPS Mail

Note: if electronic access is checked, an email will be sent from info@rrsmedical.com. Please make sure to check your bulk/spam boxes. If Imaging Films is checked in the box below, the default delivery method is CD-USPS Mail, unless otherwise specified.

PURPOSE OF RELEASE

☐ Continuing Care ☐ Transfer of Care ☐ Referral ☐ Personal
☐ Legal ☐ Insurance ☐ Disability ☐ Other _____

INFORMATION TO BE RELEASED

Dates of Service Requested: FROM _____/_____/_____ TO _____/_____/_____

☐ Entire Chart ☐ Office Notes ☐ Consults ☐ Lab Reports ☐ Radiology Reports
☐ Imaging Films ☐ Medications ☐ Immunizations ☐ Operative Reports ☐ Physical Therapy
☐ Itemized Billing ☐ Other _____

I authorize the release of information or references to the existence of and/or treatment for drug/alcohol abuse, mental health, sexually transmitted diseases, genetics, Hepatitis B or C, HIV/AIDS. This information will be released unless I indicate by checking below that I do not want such information released.

☐ DO NOT RELEASE

I authorize the disclosure of the health information for the above-named patient. This authorization is valid for 12 months from the date of signature. I understand that I may cancel this request by written notification, but that it will not affect any information released prior to notification of cancellation. I understand that the information used or disclosed may be subject to re-disclosure by the person or class of person or facility receiving it and would then no longer be protected by federal regulations. I understand that the medical provider by whom this authorization is furnished may not condition their treatment of me on whether or not I sign the authorization. There may be a charge for your records; please have facility discuss pricing as indicated.

Signature: _____ Date: _____

Reason if patient is unable to sign: _____
(Provide guardianship, executor of estate, death certificate, or power of attorney paperwork with request)