

Records Release Request

Date: _____

Patient: _____

Date of Birth: _____

I hereby authorize **McHenry County Orthopaedics** to release any and all information including medical records and/or radiographs for treatment rendered to me during the following period...

From _____ To _____

Per Illinois law, **McHenry County Orthopaedics** will charge...

\$23.80 handling fee

Actual Postage

89 cents each for pages 1-25

59 cents each for pages 26-50

30 cents each for pages 51-up

I have instructed **McHenry County Orthopaedics** to...

mail

fax

prepare for pick-up

the medical records indicated above.

Name/Address: _____

Fax Number: _____

Signature: _____

Witness: _____

For questions and/or additional information, you may contact **McHenry County Orthopaedics'** Medical Records Representative at 815/788-2009.