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AUTHORIZATION TO RELEASE COPIES OF MEDICAL RECORDS

Date: _____ Name: _____

Date of Birth: ___/___/____(MM/DD/YYYY) Social Security Number: ____-____-____
(ok to just give last 4 digits)

I hereby authorize the release of records documenting my personal healthcare to be transferred OR sent to:

To:	From:
Name: _____	The Knight Center for Integrated Health
Address: _____	Rebecca Knight, MD
_____	Ben Miles, DC
_____	Kerry Maloney, APN
	4300 N. Brandywine Dr.
	Peoria, IL 61614
	Fax: 309-692-0184

Fax: _____

Please initial below for applicable statements:

() Complete Transfer of Care effective: ___/___/_____

This will include all the following:

Visit notes, Labs, Imaging, Chiropractic, Manual Tx, Med list, refills. The last 3 are not included unless checked.

- () Review only by a consulting physician
- () Other (please explain) _____
- () INCLUDE genetic testing
- () INCLUDE records pertaining to MENTAL HEALTH
- () INCLUDE records pertaining to HIV

Signing is acknowledging that you will be responsible for the following fees. **However, if willing to accept them electronically (pdf's) we will discount the cost to be much lower and to not exceed \$25.00 (excl. postage). Most charts requested in paper will cost in the hundreds, so please choose wisely.**

Illinois 2019 Fees for Copies of Health Care Records Code of Civil Procedure 735 ILCS 5/8-2001(d)

- Handling Charge \$28.44
- Copying pages 1 through 25 - \$1.07 per page
- Copying pages 26 through 50 - \$0.71 per page
- Copying pages in excess of 50 - \$0.33 per page
- Actual postage if mailed, no charge if faxed or emailed
- Electronically delivered media, pdf's, CD-ROM is 50% of above cost or \$25 whichever less**

Patient Signature: _____ Date signed: _____

If minor, Parent or Legal Guardian Signature: _____

If unable to give consent, POA: _____

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