THE KNIGHT CENTER FOR INTEGRATED HEALTH
4300 N. Brandywine Dr • Peoria, IL 61614 • P 309.692.0123 • F 309.692.0184
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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:

Name: _____

Address: _____

_____

_____

Fax: _____

From:

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

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: _____