SCHROEDER MD
REGENERATIVE ORTHOPEDICS

Keith E. Schroeder, M.D.
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AUTHORIZATION FOR RELEASE OF CONFIDENTIAL INFORMATION

Patient Name: Date of Birth / /

Address:

City: State: Zip: Phone: ( ) -

I AUTHORIZE Keith E. Schroeder,MD Schroeder MD Regenerative Orthopedics TO RELEASE TO:

Name:

Relationship to Patient:

Address:

City: State: Zip:

THE FOLLOWING INFORMATION FROM THE ABOVE-NAMED PATIENT'S RECORDS:

Please check the appropriate box (es):

- ☐ Entire Medical Record, including X-rays*
- ☐ Entire Medical Record, excluding X-rays*
- ☐ X-rays only
- ☐ Laboratory Reports
- ☐ Operative Reports
- ☐ MRI Images & Report
- ☐ Office Visit Notes
- ☐

Other: Approximate date(s) of treatment: Purpose/Need:

I would like to arrange for the transfer of records by: □ **EMAIL** □ **PAPER**

Please check the appropriate box:

- ☐ **USPS to the delivery address** _____
- ☐ **Email to the following address**_____
- ☐ ***Pick up records at our Bartlett location *ONLY* 1110 W Schick Rd, Bartlett, IL 60103**

Signature (Patient or Legal Guardian): **Date:** / /

NOTICE TO PATIENT

I understand that this consent is valid for 180 days from the date of signature. I understand that I may revoke this consent at anytime by giving written notice to Keith E. Schroder, MD-SRO. I understand that information used or disclosed pursuant to this authorization may be subject to redisclosure by the recipient and may no longer be protected by law. This authorization will automatically expire when the information requested has been released if I have given no prior notice as stated above. I understand I have the right to review and obtain the information to be disclosed.

We require up to 15 business days after receipt of signed release to process request.