Name:
Chart:
Date:

Midwest Orthopedic Specialists

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AUTHORIZATION TO USE OR DISCLOSE HEALTH INFORMATION

Patient Name: _____ Date of Birth: _____
Address: _____ SSN: _____

1. I authorize the use or disclosure of the above named individual's health information as described below.
2. The following individual /organization is authorized to make the disclosure (organization to release the records):

   _____
3. The type of information to be used or disclosed is as follows (request only the information you want released)

   All medical records from your facility. Only records from _____ to _____.

   Consult Notes Operative reports

   Testing and/or lab results (describe the dates or type of tests you would like disclosed): _____

   _____

   X-rays and/or other imaging films (please describe the dates or types of x-ray or images you would like disclosed): _____

   Other (please describe): _____

   Medical Information only Financial Information only Medical and Financial Information

   Verbal only Written only Verbal and Written
4. I understand that the information in my health record may include information relating to sexually transmitted disease, acquired immunodeficiency syndrome(AIDS), or human immunodeficiency virus(HIV). It may also include information about behavioral or mental health services, and treatment for alcohol and Abuse. 8-18-42 308- 625.3
5. The information identified above may be used by or disclosed to the following individual/organization:
   (To whom are the records being released. — If family, list name and relationship)

   Name: _____ Records needed by date _____

   Address: _____ To be mailed (✓) _____

   _____

   _____ To be faxed (✓) _____

   Phone: _____ To be picked up (✓) _____

   Fax: _____ Date to be picked up _____

   Processed by _____ Date _____

BC4

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6. The information will be used for the following purpose (check as many as applicable):

- ☐ My personal records
- ☐ Disability Claim
- ☐ Social Service Agency
- ☐ Second opinion (as recommended by my physician)
- ☐ Referred to specialist
- ☐ Other (please describe) _____
- ☐ Attorney
- ☐ Insurance Company
- ☐ Relocation of self of family
- ☐ Second opinion (as preferred by patient)
- ☐ Transfer of care

7. I understand that I have a right to revoke this authorization at any time. I understand that if I revoke this authorization, I must do so in writing and present my written revocation to the Medical Records department. I understand that the revocation will not apply to information that has already been released in response to this authorization. I understand that the revocation will not apply to my insurance company when the law provides my insurer with the right to contest a claim under my policy.

8. This authorization will expire (insert date or event): _____.
If I fail to specify an expiration date/event, this authorization will expire 1 year from the date it was signed.

9. I understand that once the information is disclosed, it may be re-disclosed by the recipient, and federal privacy laws or regulations may not protect the information.

10. I understand authorizing the use or disclosure of the information identified above is voluntary. I need not sign this form to ensure healthcare treatment.

_____ _____
Signature of patient or legal representative (must be 18 or older) Date

If signed by legal representative, relationship to patient _____

_____ _____
Signature of Witness Date

****

OFFICE USE ONLY:

Chart # _____ Date Rec'd _____ Date Sent _____ By (staff) _____

Copy of form provided to patient? ☐ Y ☐ N