Midwest Orthopaedic
I N S T I T U T E

FAX BACK TO: 815-756-7130

Authorization for Release of Medical Information

(NOTE: For release of films use yellow Release Form)

I, _____, _____/_____/_____, _____
(Name of patient) (Date of birth) (Phone number)

_____ **authorize**
(Street Address) (City) (State) (Zip)

My records to be released from: _____
(Name)

_____
(Street Address) (City) (State) (Zip)

My records to be sent to: _____
(Name)

_____
(Street Address) (City) (State) (Zip)

The type of information to be disclosed (check all that apply):

(check)		Visit Date	(check)		Visit Date	Initials
☐	All Records	_____	☐	Medication Records	_____	
☐	Progress Notes	_____	☐	X-ray, CT, MRI (reports only)	_____	
☐	Discharge Summary	_____	☐	Lab Reports	_____	
☐	History and Physical	_____	☐	Pathology Report	_____	
☐	Consultation Report	_____	☐	Mental Health	_____	_____
☐	Operative Report	_____	☐	Alcohol/Drug Report	_____	_____
☐	Procedure: _____		☐	Sexually Trans Disease	_____	_____
☐	Other: _____					
☐	HIV (AIDS) reports _____					

(Requires your signature here)

The purpose of the disclosure is: (check one)

☐ Medical Care ☐ Payment of Claim/Benefits ☐ Personal Use
☐ Legal Investigation ☐ Insurance Application ☐ Other (please specify)_____

Permission to Release Records

I understand that I may revoke this authorization by written notification at any time following this date, except for the information which may have been released prior to the revocation. Unless otherwise specified, this consent will expire one year from the signed date. This authorization will be effective for medical records generated to the date of the signature.

I understand that in accordance with State and Federal confidentiality regulations the information disclosed may include reference to or treatment of alcohol/drug abuse, emotional illness, developmental disability, or psychiatric care only if I indicated above with my initials or signature. Further disclosure of this information without written consent is prohibited by law.

I understand that there will be a fee charged to me to cover the cost of copying and sending my records. This fee will be billed by and payable to the copy service that processes my request for copies of my medical records.

☐ One year from date this form is signed
Expiration date or condition to expire: ☐ Other:_____

_____ _____
(Signature of person giving consent) (Date signed) (Witness) (Date signed)

The signature is of the ☐ Patient ☐ Parent of Minor ☐ Legal Guardian
☐ Patient's Executor or Next of Kin
☐ Person authorized by Patient _____
(Specify relationship or authority to act)