Midwest Orthopaedic Center, SC

Authorization To Release Healthcare Information

MIDWEST ORTHOPAEDIC CENTER

MOC Account #: _____

Patient's Name: _____ DOB: _____

Previous Name: _____ SSN#: _____

I request and authorize **Midwest Orthopaedic Center, 6000 N Allen Road, Peoria, IL 61614** to release healthcare information of the patient named above to:

Name: _____

Address: _____

City: _____ State: _____ Zip: _____

Fax Number: _____ Phone Number: _____

I wish to receive my records via: ❑ **Fax** ❑ **Mail** ❑ **Electronically on a CD via U.S. mail**

❑ **Electronically via a secure portal. Email address for link:** _____

This request and authorization applies to: **select one**

❑ **Chart Abstract:** Office Notes, Radiology Reports, Special Studies Reports, Procedure/Operative Notes, Lab Results, Hospital Consults and Discharge Summaries. Dates: From _____ To: _____ Or specific date: _____

❑ **Legal Medical Record:** Chart Abstract plus any patient questionnaires/histories, orders correspondence, telephone messages and records received by other medical providers. Dates: From _____ To: _____ Or specific date: _____

❑ **Healthcare information relating to the following treatment, condition or dates only:** (Please Specify)

_____

_____

❑ Other _____

❑ **Digital Copies of X-Rays or MRI** taken at Midwest Orthopaedic Center from: Date(s) _____

I authorize the release to the person(s) listed above of any records regarding:

❑ Yes ❑ No	Behavorial Health		❑ Yes ❑ No	Sexual Assault	
❑ Yes ❑ No	Developmental Disability		❑ Yes ❑ No	AIDS/HIV	
❑ Yes ❑ No	Substance Abuse/Addiction		❑ Yes ❑ No	Child Abuse	

I understand that: a) I must revoke my authorization in writing and may do so by completing and signing the Revocation of Authorization form, DM-3523, available at my clinic's business or medical records office; b) If I revoke my authorization, it will not affect any actions already taken by Midwest Orthopaedic Center based upon this authorization; and c) I may not be able to revoke this authorization if the purpose of it was to obtain insurance. Once Midwest Orthopaedic Center has disclosed health information, the recipient may re-disclose it in some situations. Privacy laws may no longer protect the information.

This authorization expires _____ (date or event). Authorization will expire in ninety days if not otherwise specified.

Date	Signature of patient or patient's authorized representative	Relationship to patient, if not patient
_____	_____	_____

❑ **Check if patient is a minor**

MINORS - A minor patient's signature is required in order to release the following information (1) conditions relating to the minor's reproductive care including, but not limited to, contraception, pregnancy and pregnancy termination, sterilization and sexually transmitted diseases (age 14 and older), (2) alcohol and/or drug abuse (age 13 and older), and (3) mental conditions (age 13 and older).