# Authorization for Use and Disclosure of Patient Health Information

2300 53rd Avenue
Bettendorf, IA 52722
(563) 324-0615 (Fax)

520 Valley View Drive
Moline, IL 61265
(309) 762-3690 (Fax)

6101 Northwest Blvd
Davenport, IA 52806
(563) 324-0615 (Fax)

Patient Name: _______________________________________________ Patient Address: ________________________________________

City: _________________________________________________ State: _____________________ Zip Code: ______________________

Date of Birth: ________/________/________ SSN#: __________-__________-__________

Please disclose the following protected health information to: *(Name of facility, physician, or attorney this information will be given to ~ including address and phone number)*

***Records from:***

______________________________________________________

______________________________________________________

***Records sent to:***

______________________________________________________

______________________________________________________

***Preferred delivery method***:

☐ Email/Electronic delivery (email address) _________________________________ __________ ☐ Standard mail
☐ Pickup at ORA Orthopedics Office
[ ☐ Moline ☐ Bettendorf ☐ Davenport ]

***I hereby authorize ORA Orthopedics to disclose***:

☐ Clinical office notes ☐ Laboratory Reports ☐ Radiology images
☐ Operative notes ☐ Radiology Reports ☐ Other __________________________________

***Purpose of Disclosure:***

☐ Transfer of records to new provider ☐ Insurance ☐ Workers comp ☐ Military
☐ Legal/Attorney ☐ Disability determination ☐ Personal

I understand that I have the right to revoke this authorization at any time by sending a written revocation to ORA Orthopedics, Privacy Officer. If I revoke this authorization, ORA Orthopedics will no longer use or disclose my medical information for reasons covered by this authorization, except to the extent it already has relied upon this authorization. I understand that when ORA Orthopedics discloses information pursuant to this authorization, the information may no longer be protected by federal or state privacy rules and may be subject to re-disclosure by the recipient of this information.

I understand that I need not sign this authorization to assure treatment. I understand that I may inspect and/or copy the information to be disclosed. I understand that authorizing this disclosure is voluntary. I understand that if I have questions about disclosure of my health information, I may contact the ORA Orthopedics' Privacy Officer.

***Specific Authorization for Release of Information Protected by State or Federal Law:***

I understand the information below may be released and may include the following categories unless I specifically deny the release (**initial** any category **not** to be released):

______ Substance Abuse
(Initial) (Alcohol/Drug Abuse)

______ Mental Health
(Initial) (Psychological Testing)

______ HIV-Related Information
(Initial) (AIDS-Related Testing)

***This authorization will expire one year from the patient signature date.***

I understand and agree to the terms of this authorization:

____________________________________________________________________________________________________
Patient (or Patient Representative) Signature Date

If signed by Patient Representative, state authority to act on behalf of patient: ______________________________________________________

Prepared by: ______________________________ Information Sent: ________________________________________________________
Date

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