Authorization for Use and Disclosure of Patient Health Information

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

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

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

985 Avenue of the Cities #105
Silvis, IL 61282
Fax (309) 762-3690

Patient Name: ____ Patient Address: ____

City: ____ State: ______________________ Zip Code: _______________________

Date of Birth: ________/________/________ Phone Number: __________________________

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:
____
____
____

☐ Specific Dates – From ____/____/____ To ____/_____/_____

☐ Complete Medical Record

Preferred delivery method (Check only one):

☐ Email/Electronic delivery (email address)_ ____ ☐ Standard mail

☐ Pickup at ORA Orthopedics Office ☐ Moline ☐ Bettendorf ☐ Davenport ☐ Silvis

I hereby authorize ORA Orthopedics to disclose:

☐ Clinic Office Notes ☐ Physical Therapy Notes ☐ Laboratory Reports
☐ Operative Notes ☐ Radiology Reports ☐ Other ___________________________________

Radiology (X-Ray & MRI) Image Delivery Method:

☐ Electronic email delivery / Powershare

☐ CD Format (PC Readable Only)

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

Form-#209