



Authorization for Use and Disclosure of Patient Health Information

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

5250 Competition Drive
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 ____/____/____

All Dates

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 Correspondence Other _____

Radiology (X-Ray & MRI) Images – *Images will be electronically delivered*

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: _____