ELMHURST ORTHOPAEDICS

DIAGNOSTICS • TREATMENT • REHABILITATION

Authorization for Release of Information

Patient Name _____ DOB _____

Address _____

City _____ State _____ Zip _____

Phone (best daytime number)_____

I hereby authorize _____
to release information from my medical record as indicated below to:

Person/Institution/Other _____

Address _____

City _____ State _____ Zip _____

Phone _____ Fax _____

I authorize the release of information pertaining to the following time periods:

All date(s) _____ ***OR*** From date(s) _____ To Date(s) _____

INFORMATION TO BE RELEASED:

☐ ALL Records ☐ Clinic/Office Records ☐ Diagnostic Reports (lab, xray,etc) ☐ Operative Reports

☐ Physical Therapy ☐ X-Ray/MRI images/films ☐ Other _____

The following highly CONFIDENTIAL items must be checked off to be included in the disclosure:

☐ HIV/AIDS related health information/records ☐ Drug/alcohol diagnosis, treatment, referral information

☐ Behavioral or mental health information/records ☐ Genetic testing information/records

This authorization expires (date):_____. If not specified, this release will expire 1 year after the date of signature.

- I understand that I have the right to inspect and copy the information I have authorized to be disclosed by this authorization. In the event I refuse to authorize the release of the above-described information, I understand that it will not be disclosed, except as provided by law.
- I understand that the practice may not condition treatment on whether I sign this authorization, except when the provision of health care is solely for the purpose of creating protected health information for disclosure to a third party.
- I understand that information used or disclosed pursuant to this authorization may be subject to redisclosure by the recipient and may no longer be protected by law.
- I understand that this authorization is valid until it expires, unless revoked before that.
- I understand that I may revoke this authorization at any time by giving written notice to the physician of my desire to do so. I also understand that I will not be able to revoke this authorization in cases where the physician has already relied on it to use or disclosure my health information. Written revocation must be sent to the physician's office.
- I have read and understood the terms of this Authorization and I have had the opportunity to ask questions about the use and disclosure of my health information. By my signature, I knowingly and voluntarily authorize the entity identified above to use or disclose my health information in the manner described above.
- I understand that in compliance with the Illinois State Law Statute, I will pay a fee according to said statute based on page count of records to be copied. There is no charge for medical records of two year history if copies are sent to facilities/provider for ongoing care. Records older than two years are subject to fees according to Illinois State Law.

Printed name of patient, legal guardian, or authorized agent: _____

Signature of patient, legal guardian, or authorized agent: _____

Relationship to patient: _____ Date: _____