MILLER ORTHOPEDIC SPECIALISTS

Authorization for Release of Information

PATIENT NAME: _____
Last First MI Maiden or Other Name

DATE OF BIRTH: _____-____- _____ SS# _____-_____- _____ MEDICAL RECORD #_____

ADDRESS: _____CITY:_____STATE _____ZIP: _____

PHONE: Home: _____Work: _____ _____Cellular: _____
(Please complete only the phone numbers that you wish us to contact you at or leave a message at.)

I hereby authorize ***MILLER ORTHOPEDIC SPECIALISTS*** to release information from my medical record as indicated below to:

NAME: _____

ADDRESS: _____CITY: _____STATE_____ZIP: _____

PHONE: _____ FAX: _____

INFORMATION TO BE RELEASED:

Dates:

- ○ Progress notes _____
- ○ Operative report _____
- ○ Lab reports _____
- ○ X-ray reports _____
- ○ Billing record _____
- ○ MRI/X-Ray Disk _____

I specifically authorize the release of information relating to:

- ○ Substance abuse (including alcohol/drug abuse)
- ○ Mental health (including psychotherapy notes)
- ○ HIV related information (AIDS related testing)

X_____
SIGNATURE OF PATIENT OR LEGAL GUARDIAN

_____
Date

PURPOSE OF DISCLOSURE:

- ○ Changing Physicians
- ○ Legal
- ○ Other (please specify)_____

1. I understand that this authorization will expire one year after I have signed this form.
2. I understand that I may revoke this authorization at any time by notifying the providing organization in writing, and it will be effective on the date notified except to the extent action has already been taken in reliance upon it.
3. I understand that information used or disclosed pursuant to this authorization may be subject to redisclosure by the recipient and no longer be protected by Federal privacy regulations.
4. I understand that in compliance with the State of Iowa statute, ***I will pay a fee for medical records of $15.00 (1-3 pgs.); $20.00 (4-20 pgs.); $22.50 (21-25 pgs.); and $22.50 plus $1.00 per page over 25 pages***. This fee is due for medical records in the following instances: health insurance, disability insurance, liability insurance, an attorney, applications for health insurance and your own personal records. Our copy charge for x-rays is $5.00 per film. X-rays are not part of the general designated record set and are released for the purpose of another doctor's opinion or consultation and in some cases for court exhibits. However, the fee for copies of x-rays is waived, if you are referred to another physician by one of our physicians; or if you are referred for a 2nd opinion in regards to a workers' compensation claim, other exclusions are outlined in our Notice of Privacy Practices set forth by the Federal Government.

X_____ or_____
Signature of Patient Date Parent/Legal Guardian/Authorized Person Date

_____ _____
Records Received by Date Relationship to Patient

FOR OFFICE USE ONLY
DATE REQUEST FILLED:_____ BY:_____
IDENTIFICATION PRESENTED:_____ FEE COLLECTED: $_____

Revised 07/1/2019.cd