

**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:**

- |                       |                  |       |
|-----------------------|------------------|-------|
|                       | <b>Dates:</b>    |       |
| <input type="radio"/> | Progress notes   | _____ |
| <input type="radio"/> | Operative report | _____ |
| <input type="radio"/> | Lab reports      | _____ |
| <input type="radio"/> | X-ray reports    | _____ |
| <input type="radio"/> | Billing record   | _____ |
| <input type="radio"/> | 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) \_\_\_\_\_

- I understand that this authorization will expire one year after I have signed this form.
- 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.
- 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.
- 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 2<sup>nd</sup> 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		Parent/Legal Guardian/Authorized Person
_____		_____
Date		Date
_____		_____
Records Received by		Relationship to Patient
_____		_____
Date		

**FOR OFFICE USE ONLY**

DATE REQUEST FILLED: \_\_\_\_\_ BY: \_\_\_\_\_

IDENTIFICATION PRESENTED: \_\_\_\_\_ FEE COLLECTED: \$ \_\_\_\_\_