AUTHORIZATION TO RELEASE INFORMATION

Please allow 7-10 Business Days to process

STEINDLER ORTHOPEDIC CLINIC

Account #: _____

Patient's Legal Name (please print)**:** _____ **DOB:** ____/____/____

Phone Number: _____ **Current Address:** _____

By signing this form, I allow Steindler Orthopedic Clinic (SOC) to release medical information via: ☐ **copies** ☐ **verbal** concerning the above named patient to the following:

Name of Person and/or Institution to Send Records to: _____

Please send records via:

☐ Patient pick-up Iowa City Burlington (circle one)

☐ Mail: _____ Complete Mailing Address/Street/PO Box

☐ Fax: _____ (Imaging can not be faxed)

_____ City, State, Zip Code

Required to Process Request

Please check the information to be disclosed:

☐ All Imaging/Records - Specify dates: _____

☐ Imaging CD - Specify area of the body and dates: _____

☐ Consultation/Referral reports - Specify Provider and dates: _____

☐ History and Physical - Specify Provider and dates: _____

☐ Imaging reports - Specify area of the body & dates: _____

☐ Current & Past Medical Information sheets: _____

☐ Surgery/discharge reports - Specify Provider and dates: _____

☐ Billing Information - Specify: _____

☐ Other - Specify: _____

I understand that the information to be released may include information in the following categories unless I specifically deny the release (initial next to any category **NOT** to be released):

_____ Substance Abuse _____ Mental Health _____ HIV- related information

Indicate the reason for release:

☐ Personal File ☐ Disability/FMLA ☐ Legal ☐ Physical Therapy ☐ 2nd Opinion

☐ Transferring Care ☐ Other Medical Care ☐ Other: _____

I understand that SOC will not condition treatment, payment, enrollment or eligibility for benefits on whether I sign this authorization form, except in the following situations:

- If the medical information to be disclosed will result from treatment for research purposes, SOC will not provide the treatment if I am unwilling to sign this authorization form.
- If the information to be disclosed will result from treatment provided to me solely for the purpose of creating information to be disclosed to a third party, SOC will not provide the treatment if I am unwilling to sign this authorization form.

I understand that I may revoke this authorization by sending a written request for revocation to SOC. If I revoke this authorization, SOC will no longer use or disclose my medical information for the reasons covered by this authorization, except to the extent it has already relied upon this authorization. I understand that when SOC 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 the information.

This agreement will expire one year from the date of signature, unless previously revoked or otherwise indicated (specify number of days or months) _____.

_____ _____

Signature of Patient or Patient Representative **Date**

If signed by Patient Representative, print name and state the authority to act on behalf of the patient: _____