AUTHORIZATION FOR RELEASE OF MEDICAL RECORD INFORMATION

PATIENT NAME: _____ BIRTHDATE: _____
COMPLETE ADDRESS: _____
PHONE: _____ Email: _____
I authorize: _____ OrthoIllinois _____ OrthoIllinois Surgery Center
Delivery Format: ____ Secure Electronic Delivery ____ Fax ____ Mail Delivery

To Release To:

_____
(Name)

_____
(Address)

Phone: _____ Fax: _____

For the purpose of: ___ Personal ___ Physician ___ Insurance disability ___ Legal ___ Other

Date(s): From: _____ To: _____

INFORMATION TO BE RELEASED: ____ Complete record ____ Physician Notes ____ X-rays only ____ Diagnostic Testing
Specific Information: _____

- I understand that I may revoke this authorization in writing at any time except to the extent that action has been taken in reliance upon this authorization (45 CFR 164.508 ©(2)(i)).
- I understand that treatment or payment cannot be conditioned on my signing this authorization, except in certain circumstances such as for participation in research programs, or authorization of the release of testing results for pre-employment purposes (45 CFR 164.508 (c) (2)(i)).
- I understand that my records are confidential and cannot be disclosed without my written authorization except when otherwise permitted by law. Information used or disclosed pursuant to this authorization may be subject to re-disclosure by the recipient and no longer protected.
- I understand that the specified information to be released may include, but is not limited to: history, diagnosis, and/or treatment of drug or alcohol abuse, mental illness, communicable disease, including Human Immunodeficiency Virus (HIV) and Acquired Immune Deficiency Syndrome (Aids) (45 CFR 164.508(c)(2)(i)).

I have read the information provided on this release form and do hereby acknowledge that I am familiar with and fully understand the terms and conditions of this authorization.

_____ _____
(signature of patient/parent/guardian or authorized representative Date

This authorization will not expire from the above date unless I specify an expiration date: _____
To check on the status of your request: https://www.orthoillinois.com/resources/patient-info
or call 866-442-9026 or email at information@scanstat.com

... a higher standard of care.