



Authorization for Release of Information

PATIENT NAME: _____
LAST FIRST M.I. MAIDEN OR OTHER NAME

DATE OF BIRTH : _____ - _____ - _____ SS#: _____ - _____ - _____ MEDICAL RECORD #: _____
MO. DAY YR.

ADDRESS: _____ CITY: _____ STATE: _____ ZIP: _____

I hereby authorize Midwest Sports Medicine & Orthopaedic Surgical Specialists Ltd. and its affiliates to release information from my medical record as indicated below to:

NAME: _____

ADDRESS: _____ CITY: _____ STATE: _____ ZIP: _____

PHONE: (_____) _____ FAX: (_____) _____

INFORMATION TO BE RELEASED BELOW FOR DATES: _____

PLEASE MARK **ALL** THAT APPLY:

| | | |
|---|---|--|
| <input type="checkbox"/> Complete Health Record | <input type="checkbox"/> Therapy Notes | <input type="checkbox"/> X-ray / MRI Films |
| <input type="checkbox"/> History and Physical Exams | <input type="checkbox"/> Consultation Reports | <input type="checkbox"/> Lab Reports |
| <input type="checkbox"/> Operative reports | <input type="checkbox"/> Discharge Summary | <input type="checkbox"/> EKG Reports |
| <input type="checkbox"/> Progress Notes | <input type="checkbox"/> X-ray / MRI Reports | |
| <input type="checkbox"/> Other: _____ | | |

PURPOSE OF DISCLOSURE: Workers Compensation Consultation/second opinion Continuing care
 Legal School Insurance (e.g., Life, Voluntary) Changing physicians
 Other (please specify): _____

1. I understand that this authorization will expire on (Date) _____ or 90 days after I have signed the 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 in compliance with the State of Illinois statutes, I will pay a fee of \$_____ (Print the Fee Charged). There is no charge for medical records if copies are sent to facilities for ongoing care or follow up and the request is received directly from the facility.

OR

SIGNATURE OF PATIENT DATE PARENT/LEGAL GUARDIAN/AUTHORIZED PERSON DATE

FOR OFFICE USE ONLY

DATE REQUEST COMPLETED: _____ EMPLOYEE NAME: _____
IDENTIFICATION PRESENTED: _____ TYPE _____ FEE COLLECTED: \$ _____