IOWA ORTHO
BONE • MUSCLE • JOINT • SPINE

450 Laurel St. Ste A | Des Moines, IA 50314
Phone: 515-247-8400 | Fax: 515-362-7918
Email: medrec@iowaortho.com

Authorization for Release of Medical Information

#1 Patient Information	Name (Legal/Maiden/Other): _____ DOB: _____ Address: _____ City: _____ State: _____ Zip: _____ Phone: (_____)_____ Email Address: _____
#2 Who will receive your information?	Receiving Entity: _____ Address: _____ City: _____ State: _____ Zip: _____ Phone: (_____)_____ Fax: (_____)_____
#3 Who will send your information?	Provider/Facility Name: _____ Address: _____ City: _____ State: _____ Zip: _____ Phone: (_____)_____ Fax: (_____)_____
#4 Information to be sent:	Only service dates from: _____ to _____ ☐ Entire Record ☐ Laboratory Reports ☐ CD of Images (MRI/CT, X-rays, etc.) ☐ OP Reports ☐ Other (specify information to be released): _____
#5 Purpose	☐ Legal ☐ 2nd Opinion/Transfer of care ☐ FMLA/STD ☐ Military ☐ Other _____
#6 Choose Format	☐ Fax: (____)_____ ☐ Email to: _____ ☐ Mail to : _____ City _____ State____ Zip_____ **FORMAT: (Choose one)** ☐ CD of records ☐ CD of images ☐ Printed paper copy ☐ Electronic *****Please allow 30 days for processing for all medical record requests******
#7 Submit	Email this form to medrec@iowaortho.com, fax to 515-362-7918, return to any Iowa Ortho location or call 515-247-8400 to provide verbal authorization

This authorization expires: _____ (date or event). Authorization will expire in 365 days if not specified.

Patient Signature/Rep: _____ Relationship_____ Date: _____

I understand that I may revoke this authorization at any time, except to the extent that action has already been taken in reliance upon it, and by giving written notice to Iowa Ortho Medical records department. I understand that I have the right to inspect the information to be disclosed upon the proper notification to and under conditions established by the source facility. I understand that my health care and payment for my health care will not be affected if I do not sign this form. I understand this authorization is voluntary. I understand that if the recipient of this information is not a health plan or provider, the released information may no longer be protected by federal privacy regulations and may be subject to re-disclosure. I understand that I am entitled to receive a copy of this completed authorization form. Please be aware that federal and state law allows healthcare providers 30 days to respond to written requests for records.

Federal and state laws allow a fee to be charged for copying patient records and I will be responsible for the payment of such fees, unless the records are sent directly to a physician or healthcare facility. 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. Prohibition of re-disclosure: This form does not authorize re-disclosure of medical information beyond the limits of this consent. Where information has been disclosed from records protected by federal law for alcohol/drug abuse records or by state law for mental health records, and HIV/AIDS tests results, federal requirements (42 CFR Part2) and state requirements (IA Code ch.228&ch.141) (740 Ill. Comp. Stat. § 110/5) (Wis. Code §§252.15(6), 50.30) prohibit further disclosure without the specific written consent of the patient, or as otherwise permitted by such law and/or regulations. A general authorization for release of medical or other information is not sufficient for these purposes. Civil and/or criminal penalties may result from unauthorized disclosure of alcohol/drug abuse, mental health or HIV/AIDS related testing and or treatment.