MIDWEST ORTHOPAEDICS AT RUSH (MOR)
AUTHORIZATION FOR RELEASE OF PROTECTED HEALTH INFORMATION

Please note that there may be a cost associated with processing copies of Medical Records.
After completing the form below please fax it to: (708) 409-5179

PATIENT INFORMATION:

Patient's Name: _____ Date of Birth: _____/_____/_____

Address: _____ Telephone: _____

City: _____ State: _____ Zip Code: _____

MEDICAL INFORMATION REQUESTED:

Identify Specific Physician or Department: _____

Date or Date Range: _____ /_____ / _____ to _____ /_____ / _____

RELEASE REQUESTED MEDICAL INFORMATION TO:

☐ Check box if same as patient information above

Individual or Organization's Name: _____ Telephone #: _____

Relationship to Individual: ☐ Personal Representative ☐ Spouse/Relative

☐ Attorney ☐ Other: _____

Purpose: ☐ Continuation of Care ☐ Personal Records ☐ Insurance ☐ Legal ☐ Other: _____

Method of Delivery:

☐ By secure electronic delivery (requires internet access): Email Address: _____

☐ By US Mail: Mailing Address: _____

City: _____ State: _____ Zip Code: _____

REQUESTED MEDICAL INFORMATION:

☐ All Medical Records	☐ X-Ray	☐ Billing Statement/Claim
☐ Physical Therapy Note	☐ Images*	☐ Other, please specify:
☐ Laboratory Data	☐ Reports	_____
☐ EMG/EEG Reports	☐ MRI/CT	_____
	☐ Images*	_____
	☐ Reports	

*Images- $10.00, provided on CD (Note: For Microsoft Windows Based Operating Systems)

Note: Medical records are prepared through MOR and processed through CIOX Health in Atlanta, GA
WE DO NOT FAX MEDICAL RECORDS

1611 West Harrison Street, Suite 300 | Chicago, IL 60612
PHONE (312) 432-2316 | FAX (708) 409-5179 | medicalrecordsdept@rushortho.com

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***Patient's Name**: _____ **Date of Birth**: _____/_____/_____

ADDITIONAL INFORMATION TO BE RELEASED:
Patient initial and date required for each item

☐ Genetic testing
Initial _____ Date ___ /___ /___

☐ Drug/Alcohol
Initial _____ Date ___ /___ /___

☐ HIV
Initial _____ Date ___ /___ /___

☐ Mental Health/Development Disability
Initial _____ Date ___ /___ /___

AUTHORIZATION:
I authorize Midwest Orthopaedics at RUSH to disclose my protected health information (PHI) in the manner described below. I understand that this authorization is voluntary. I also understand that my PHI may be redisclosed by the person or entity receiving my PHI from Midwest Orthopaedics at RUSH, and may no longer be protected by the Federal Regulations or state law. I understand that my health care will not be affected if I do not sign this form.

Please note that this authorization will not apply to any dates of service that occur after the date of signature.

I understand that I may revoke this authorization at any time by notifying Midwest Orthopaedics at RUSH in writing. I understand that revocation of this authorization will not affect any actions already taken by Midwest Orthopaedics at RUSH in reliance on this authorization. I understand that I have the right to review my health information before release. I also understand that I have a right to receive a copy of this authorization.

Signed: _____ Dated: _____/_____/_____

If not signed by this patient, please indicate relationship:

☐ Parent or Guardian ☐ Guardian or legal representative of an incompetent patient

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