MIDWEST ORTHOPAEDICS AT RUSH
AUTHORIZATION FOR RELEASE OF PROTECTED HEALTH INFORMATION

Patient's Name: (Print) _____ Date of Birth: _____

Address: _____ Telephone #: _____

City: _____ State/Zip Code: _____

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

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 re-disclosed 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 check below any or all of the following including CD, Film, and X-ray information that may be disclosed by Midwest Orthopaedics at RUSH:

Identify Specific Physician/Location: _____

[ ] All Medical Records
[ ] Laboratory Data
[ ] Radiology Reports
[ ] HIV Test Results
[ ] Psychotherapy Notes
[ ] Alcohol Abuse Records
[ ] Claims/Billing Information
[ ] CD $10.00 (Note: For Microsoft Windows Based Operating Systems Only)
[ ] X-Rays/MRI/CT
[ ] Other _____

[ ] Specific date or range of dates: _____ to _____

Relationship to Individual: **[ ] Personal Representative** **[ ] Attorney** **[ ] Spouse/Relative** **[ ] Other _____**

This authorization will be used for: _____

Method of Delivery: Check the box for preferred method of delivery:

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

[ ] By **US Mail: Mailing Address:** _____
_____
_____

I understand that this authorization will expire on _____ or one year from the date of my signature below, whichever is earlier.

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

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