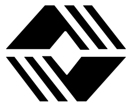

DES MOINES ORTHOPAEDIC SURGEONS, P.C.

AUTHORIZATION FOR RELEASE OF MEDICAL INFORMATION

Make sure ALL blanks are filled in on both sides and signature is on the back.
Failure to do so will make this authorization invalid and will prevent the release of information.

Patient Name ____ Phone ______________________

Address ____

Date of Birth _____________________ Soc. Sec. _________________________

Parents/Previous Name(s): ____

==

DMOS Physician ____

Address **Des Moines Orthopaedic Surgeons, P.C.**

☐ 6001 Westown Parkway
West Des Moines, IA 50266

☐ 1301 Penn Ave., Suite 213
Des Moines, IA 50316

☐ 311 South Clark Street, Suite 285
Carroll, IA 51401

I authorize my DMOS physician and /or administrative and clinical staff to disclose the following protected health information to:

Name ____

Address ____

____

☐ Work status / Return to work or School / PE notes
☐ Forms to be completed. Must specify (ex. FMLA, disability) ______________________________
(Fee of $15 per form is due prior to completion)
☐ Complete Medical Records
☐ Medical Records for following dates only. Dates **from** ____________________ **to** __________________
☐ X-ray Data; Date(s) ____
☐ Copies of X-rays ($5.00 per sheet; $10 per CD)
☐ Copies of MRI ($10.00 per sheet; $10 per CD)

Date Needed : _______________________

==

This protected health information is being used or disclosed for the following purposes:

☐ Transferring Medical Care ☐ Moving ☐ Personal – per patient request
☐ Insurance Coverage ☐ Attorney/Court Case ☐ Other ____________________________

==

This authorization shall be effective until:

☐ Date ______________________ (not to exceed one year)
☐ Completion of treatment for this current injury by the above specified DMOS physician
☐ Event ______________________ (must specify)

at which time this authorization to use or disclose this protected health information expires (not to exceed one year). If a box not completed, then it will be assumed that this is a one-time release only.

==

REVERSE SIDE MUST ALSO BE COMPLETED

SPECIFIC AUTHORIZATION FOR RELEASE OF INFORMATION PROTECTED BY STATE OR FEDERAL LAW

I SPECIFICALLY AUTHORIZE the release of confidential information relating to: (Circle "Yes" or "No")

Yes / No 1. Mental Health (includes psychological testing)
Yes / No 2. Substance abuse (Alcohol/Drug)
Yes / No 3. HIV or AIDS-related

Authorized Signature: ______________________________________

==

I understand that I have the right to revoke this authorization, in writing, at any time by sending such written notification to DMOS's Privacy Officer. Please refer to DMOS's Notice of Privacy Practices.

I understand that a revocation is not effective to the extent that DMOS has relied on the use or disclosure of the protected health information or if my authorization was obtained as a condition of obtaining insurance coverage and the insurer has a legal right to contest a claim.

I understand that information used or disclosed pursuant to this authorization may be subject to redisclosure by the recipient and may no longer be protected by federal or state law.

DMOS will not condition my treatment on whether I provide authorization for the requested use or disclosure.

SIGNATURE OF PATIENT OR PERSONAL REPRESENTATIVE ____________________________________ **DATE** _______________

PRINTED NAME OF PATIENT OR PERSONAL REPRESENTATIVE ____

RELATIONSHIP TO PATIENT, IF NOT SIGNED BY PATIENT ____

OFFICE USE ONLY

PICKED UP: **YES** **NO**

IF YES: **Date** ____________; **Time** ______________ **DMOS Initials** _____________

Updated: 3/11/08