Orthopaedic Outpatient Surgery Center, L.C.

AUTHORIZATION FOR RELEASE OF MEDICAL RECORDS

Patient Name	Date of Birth
Date of Surgery Performed	Last 4 of Soc.Sec #
Any previous names under which records may be kept?	

RECIPIENT: (Who is to receive this information, where is it to be sent?)

Name		
Address		
City	State	Zip
Telephone number ( )	Fax number	

☐ Documents to be picked up at OOSC by patient Date _____

☐ Documents to be picked up at OOSC by: Name: _____
Relationship to patient: ☐ spouse ☐ legal representative ☐ other_____
☐ Documents to be faxed / mailed to the recipient documented on this release form.

INFORMATION REQUESTED:

☐ Complete Records ☐ Operative Report ☐ other _____
☐ EKG, Lab Data ☐ Anesthesia Record
☐ Discharge Summary ☐ Pathology Report

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

☐ Personal-per patient request ☐ Coordination of care ☐ Transfer of care ☐ Moving
☐ Insurance coverage ☐ Attorney ☐ Other

The authorization is effective for one year from the date on which it was signed. 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, by giving written notice to Orthopaedic Outpatient Surgery Center, L.C. Medical Records Department. I understand that I have the right to inspect the information to be disclosed upon the proper notification to and appropriate conditions established by Orthopaedic Outpatient Surgery Center, L.C. Medical Records Department. Orthopaedic Outpatient Surgery Center will not condition my treatment on this authorization.

PROHIBITION ON REDISCLOSURE

This form does not authorize redisclosure 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, federal requirements (42C.F.R Part 2) and state requirement (Iowa Code Ch. 228) prohibit further disclosure without the specific written consent of the patient, or as other wise permitted by such law and/or regulations. A general authorization for the release of medical or other information is not sufficient for these purposes. Civil and/or criminal penalties may attach for unauthorized disclosure of alcohol/drug abuse or mental health information.

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Signature of Patient
Or Legal Representative_____ Date _____

Relationship to Patient if not signed by Patient _____