Mid-America Orthopedics

Authorization for Release of Information

Patient Name: _____ Date of Birth: _____ SS#: _____
Phone #: _____
I hereby authorize _____ (print name of provider or facility) to release information from my medical record as indicated below to:
Name: _____ Address: _____
City: _____ State: ____ Zip: _____ Phone: _____ Fax:_____

Information to be released:
____ All records ____ Progress notes ____ Lab reports ____ Xray reports ____ Surgery reports
Other: _____

Dates of service to be released: _____

I specifically authorize the release of information relating to:
____ Substance abuse (including alcohol/drug abuse)
____ Mental health (including psychotherapy notes)
____ HIV related information (AIDS related testing)
Signature of patient or legal guardian: _____ Date: _____

Purpose of disclosure: ____Changing physicians ____Consult/Second Opinion ____Continuing care
____Legal ____School ____ Insurance ____Workers Compensation ____ Other: _____

In signing this authorization, I understand and acknowledge the following (initial in the space provided):
____ I understand that this authorization is voluntary and that I may refuse to sign it. This is in the event that my medical records have been requested by a third party.

____ I understand that my refusal to sign this authorization will not affect my ability to obtain treatment or eligibility for benefits unless allowed by law.

____ I understand that I may revoke this authorization at any time by notifying the Practice in writing of my intent to revoke this authorization, except to the extent that action has been taken in reliance on this authorization. Any notice of termination must be sent to the Privacy Officer, 1923 N. Webb Rd., Wichita, KS 67206.

____ I understand that, unless otherwise revoked, this authorization will expire one (1) year from date of signature below.

____ I understand that once the disclosures authorized have been made, the information disclosed may be subject to re-disclosure by any recipient and no longer protected by federal privacy laws.

____ I understand that there may be a medical records copying fee that I may be responsible for. There is no charge for medical records sent to another healthcare facility.

I, the undersigned, do hereby swear that I am the above-mentioned patient or legal representative of the above-mentioned patient. I have read and understood the above information.

Signature of Patient/Legal guardian Date