CAPITAL ORTHOPAEDICS & SPORTS MEDICINE

William R. Boulden, MD
William C. Jacobson, MD
Michael S. Lee, DPM
Teri S. Formanek, MD
Gregory J. Yanish, MD
Donna J. Bahls, MD
Brian M. Crites, MD
Mark D. Fish, DO
Jill A. Frerichs, DPM
Todd C. Peterson, DO

AUTHORIZATION FOR RELEASE OF INFORMATION

Make sure all blanks are filled in. Failure to do so may prevent or delay release of information.
Fax back to 515-222-4483 or email to medicalrecords@dsmcapitalortho.com

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

***Release From*:** **Name:**_____
(medical provider) **Address:**_____

Release To: **Name:**_____
Address:_____

Reason for Request:

☐ I am transferring my healthcare to another provider
☐ I am moving (new address): _____
☐ FMLA/Disability (please describe): _____
****$25.00 processing fee applies per form***
☐ Other: _____

Information Requested:

☐ Complete Medical Record ***(not including radiology disk)***
☐ Complete Medical Records to include Radiology Disk
☐ Partial medical records from: _____ to _____

**As of May 1st, 2017 all medical record inquiries are processed through DataFile Technologies. Processing fees for these requests may vary. If you have any additional questions or concerns, please contact DataFile Tech. directly at 816-437-9134*

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

I understand that the information to be released may include information in the following categories unless I specifically **deny** the release (initial in the box of any category **not** to be released)

_____1. Substance abuse (alcohol/drug)
_____2. Mental Health (includes psychological testing, depression, anxiety)
_____3. HIV-related information (including AIDS-related testing)

The authorization is effective for one year from the date on which is was signed. *I understand that I may revoke this authorization at any time, extent that action has already been taken in reliance upon it, by giving written notice to Capital Orthopaedics and Sports Medicine, P.C. I understand that I have the right to inspect the information to be disclosed upon the proper notification and under appropriate conditions established by Capital Orthopaedics and Sports Medicine, P.C.*

PROHIBITION ON RE-DISCLOSURE: This form does not authorize re-disclosure 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 or mental health records, federal requirements (42 C.F.R. Part 2) and state requirements (Iowa Code ch.228) 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.

_____ _____
Signature of Patient or Patient Representative **Date**

If signed by Patient Representative, print name and state the authority to act on behalf of the patient, below:

Print Name: _____ ***Relationship to Patient:*** _____