IOWA ORTHO
A CENTER OF EXCELLENCE®

Authorization to Release Medical Information

Last Name: _____ First Name: _____ MI: _____

Previous Name: _____ DOB: _____

Address: _____

City: _____ State: _____ Zip: _____

Phone: _____ Email: _____

Step #1 – Select one of the options below

- ☐ Option 1 - I want Iowa Ortho to send my records to the following (list out in the next step)
- ☐ Option 2 - I want Iowa Ortho to receive my medical records from the following (list out in the next step)

Step #2 – Where do I want Iowa Ortho to either receive or send my medical records?

Name	Address	City, St, Zip	Phone	Fax

Step #3 – What types of records should be sent? Date Range: From _____ To _____

- ☐ Clinical/Progress notes ☐ Operative/Procedure reports ☐ Images (MRI, CT, Xray, etc…)
- ☐ Transfer of Care ☐ Test Results/Reports (Labs, Xray, MRI, CT, etc…)
- ☐ Other: _____

Step #4 – Tell us the purpose of your request

- ☐ Transfer of Care ☐ Personal Copy ☐ Legal Purpose ☐ Military
- ☐ 2nd Opinion ☐ FMLA/STD ☐ Other: _____

Step #5 – If these records are for you personally and not being sent elsewhere please tell us how you would like them transmitted. (I understand that there is a $25 fee. There is no fee when sending directly to a medical office or facility.)

- ☐ Email (listed above) ☐ Mail ☐ In office pickup (450 Laurel St., Des Moines only)

Step #6 – Sign and submit

- ☐ Email to medrec@iowaortho.com ☐ Fax to 515-362-7918 ☐ Return to any Iowa Ortho location

_____ _____ _____

Signature of Patient/Parent/Guardian or Authorized Representative
Signature by hand required

Relationship to Patient

Date
*****Expires 1 year from date of signature unless otherwise noted.***

I understand that my medical record may also include information on diagnosis/treatment related to psychiatric or psychological conditions, chemical dependency/alcohol abuse, communicable or infectious diseases (ie. AIDS, HIV, ARC, TB, and hepatitis). I hereby waive any privilege concerning such information for the purpose(s) of releasing it to the party or parties authorized above. I also release Iowa Orthopaedic Center and their officers, trustees, agents, and employees from any and all liabilities, damages, and claims which might arise from the release of the health information authorized by me above. In cases where someone other than the patient executes the authorization, I understand documentation may be required to support the disclosure of personal health information as required by state and federal law. In most cases, records are processed within seven days. Please be aware that federal and state law allows healthcare providers 30 days to respond to written requests for records.

Federal and state laws allow a fee to be charged for copying patient records and I will be responsible for the payment of such fees, unless the records are sent directly to a physician or healthcare facility. Iowa Ortho contracts with DataFile Technologies, LLC (Processor) to copy and provide all medical records requested from our office. Copy charges plus postage will be invoiced to you from Processor with all of the necessary directions to receive your records. By signing this authorization, you are agreeing to pay outside company for your records.

I have read the information provided on this release form and do hereby acknowledge that I am familiar with and fully understand the terms and conditions of this authorization. I understand that I have a right to revoke this authorization at any time and that it must be done in writing to Iowa Ortho.