Authorization for Release of Protected Health Information
The undersigned authorizes:
OAK Orthopedics
400 S. Kennedy Dr., Suite 100 Bradley, IL 60915
Phone: 815-928-8050 x 523 Fax: 800-781-1502
to release my health information as noted below:

Patient Identification

Patient Name: ______________________________ Date of Birth: ____________

Address: ______________________________ SSN (last 4 digits): ____________

______________________________ Telephone: ____________

Information to be sent to:

Name/Facility: ____________________ Attention To: ____________

Address: ____________________ Phone: ____________

City: ____________ State: ________ Zip: ________

Email Address: ______________________________

Fax(for continuing care only): ______________________________

Delivery Method:

- ☐ **Electronically via Email (Secure Portal)**
- ☐ USPS Mail
- ☐ Electronically via CD
- ☐ Fax (continuing care only)
- ☐ Pick up at OAK office (forms only)

Information to be Released (Medical Record requests only):

- ☐ Entire Chart
- ☐ Laboratory test results
- ☐ Rehab Service Notes
- ☐ Consults
- ☐ Office Notes
- ☐ Radiology Reports
- ☐ Neurology
- ☐ Itemized Billing
- ☐ Operative reports
- ☐ History & Physical Exam
- ☐ X-ray or MRI films CD
- ☐ Other: ____________

Dates of Service, Body Part, or Treating Doctor: ______________________________

Note: if you fail to specify, 1 year of records will be provided

Purpose of Request:

☐ Transfer/Referral ☐ Personal ☐ Legal ☐ Billing or claims payment ☐ Other: ____________

Disability Forms:

☐ I authorize the release of supporting medical records to supplement my leave claim.

☐ I am requesting leave starting: ______________________________

☐ I am requesting intermittent leave:

Reason: ______________________________

Frequency: ____________ times per ________ week ________ month

☐ In-House Disability Form (specify Doctor): ______________________________

Forms Completion:

A fee of $35.00 per form is due prior to completion of form(s).
You will be contacted by Quest HIMS with payment options.

Note from patient: ______________________________

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I understand that my medical or billing record may contain information in reference to drug and/or alcohol abuse, psychiatric care, sexually transmitted disease, Hepatitis B or C testing, and/or other sensitive information. ☐ **I do not want this information to be released.**
I understand that my medical or billing record may contain information in reference to HIV/AIDS (Human Immunodeficiency Virus/Acquired Immunodeficiency Syndrome) testing and/or treatment. ☐ **I do not want this information to be released.**
Except to the extent that action has already been taken in reliance on this Authorization, you have the right to revoke this Authorization by submitting a notice in writing to the Department of HIS or other Department to whom you are authorizing disclosure. Unless revoked, this Authorization will expire on the following date or event ______________________________, or 90 days from date of signature, unless otherwise specified.
I understand that the information released pursuant to this Authorization may be subject to release by the recipient and no longer protected by the Health Insurance Portability and Accountability Act of 1996. The facility, its employees, officers and physicians are hereby released from any legal responsibility or liability for disclosure of the above information to the extent indicated and authorized herein.
Your provider will not deny treatment if you do not sign this form. You may inspect or copy your protected health information. The cost of obtaining copies of your medical records will be according to the OCR guidelines. If the request is for continuing care and provided directly to a physician, all fees associated with the release of information will be waived and provided free of charge. By signing below, you authorize your provider, identified above, to release your protected health information specified above.
All Requests for Information will be fulfilled by Quest HIMS. Any correspondence, as well as payment should be directed to Quest HIMS at 618-355-9550.

Signature: ______________________________ Date: ____________

Authority to Sign - if not patient: ____________________ Witness: ____________________

Office Use Only: ☐ Billable ☐ Nonbillable