DMOS ORTHOPAEDIC CENTERS

Authorization to Release of Information

Step #1 – Patient information:

Last Name: _____ First Name: _____ MI: _____

Previous Name: _____ DOB: _____

Address: _____

City: State: Zip: _____ Phone: _____ Email: _____

Step #2 – Select one of the options below:

☐ Option 1 - I want a copy of records for myself.
☐ Option 2 - I want DMOS to send my records to the following person or place (list out below).
☐ Option 3 - I want DMOS to get my records from the following person or place (list out below).

Name	Address	City, State, Zip	Phone Number	Fax Number

Please enter the name of the DMOS physician who treated the condition:

_____

Step #3 – What types of records should be sent?

☐ Complete Medical Records
☐ Medical Records for following dates from _____ To _____
☐ Return to Work or School Status / PE notes

Step #4 – Medical Imaging Records requested?

These formats will be sent electronically:

☐ Copies of X-Rays sent to physician
☐ Copies of MRI sent to physician
☐ Copies of CT sent to physician
☐ Copies of your DMOS images (X-rays, MRI, CT) for personal use. You will receive an email with instructions for PocketHeath.

Step #5 – Purpose of release:

☐ Personal
☐ Legal Purpose
☐ Military
☐ 2nd Opinion
☐ Insurance
☐ Other: _____

Step #6 – Please tell us how you would like to receive your paper records:

Hassle Free Options:

☐ Mail to the address(es) above
☐ Email to the email address above
☐ Fax to the number above

In office pickup at:

☐ 6001 Westown Pkwy, West Des Moines, IA
☐ 350 NE 36th Street, Ankeny, IA
☐ 4850 100th Street, Urbandale, IA
☐ 1301 Penn Ave, Ste 213, Des Moines, IA

Step #7 – Please email to medicalrecords@dmos.com, Fax to 515-224-5337 or return to any DMOS office.

_____ _____

Signature of Patient/Parent/Guardian or Authorized Representative **Date**

Please read the disclosure: This authorization is effective for _____ months but no longer than 1 year from the date on which it was signed. (If left blank this document is good for 1 year from the signature date. 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 the Medical Records Department of the source facility. I understand that I have the right to inspect the information to be disclosed upon the proper notification to and under conditions established by the source facility. I understand that my health care and payment for my health care will not be affected if I do not sign this form. I understand this authorization is voluntary. I understand that if the recipient of this information is not a health plan or provider, the released information may no longer be protected by federal privacy regulations and may be subject to re-disclosure. I understand that I am entitled to receive a copy of this completed authorization form. **Prohibition of 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 for mental health records, and HIV/AIDS tests results, federal requirements (42 CFR Part2) and state requirements (IA Code ch.228&ch.141) (740 Ill. Comp. Stat. § 110/5) (Wis. Code §§252.15(6), 50.30) prohibit further disclosure without the specific written consent of the patient, or as otherwise permitted by such law and/or regulations. A general authorization for release of medical or other information is not sufficient for these purposes. Civil and/or criminal penalties may result from unauthorized disclosure of alcohol/drug abuse, mental health or HIV/AIDS related testing and or treatment.

OFFICE USE ONLY - PICKED UP: YES NO IF YES – DATE: _____ DMOS INTIALS: _____