MIDWEST OCCUPATIONAL MEDICINE LTD

325 E. Madison Ave.
Wood River, IL 62095
618-251-5202 Fax 618-251-5118

AUTHORIZATION FOR THE USE OR RELEASE OF PROTECTED HEALTH INFORMATION

Name of Patient (Please Print)
Place Text Here

Date of Birth
Place Text Here

Street Address City State Zip
Place Text Here

Phone
Place Text Here

Maiden name or other name used for records

Practice Use: MedRec#

I hereby authorize (Please Print)

Place Text Here

To release to: (Please Print)

Place Text Here

The following information from my records:

- ❑ Complete Health Record(s)
- ❑ History & Physical
- ❑ Radiology Reports
- ❑ Operative Report
- ❑ Laboratory Report
- ❑ Pathology Reports
- ❑ Only Health Records from Dr.(s) _____
- ❑ Other (please specify)_____

Covering the period from _____ to _____

_____(Initial) I understand that this authorization will include information relating to:

- ✓ Acquired Immunodeficiency Syndrome (AIDS) or Human Immunodeficiency Syndrome (HIV) infection
- ✓ Psychiatric care
- ✓ Treatment for alcohol and/or drug abuse
- ✓ Genetic Testing

If any, except as specifically stated here: _____

This information is to be disclosed for the purpose of _____
The date, extent or condition upon which this authorization expires is _____ not to exceed 24 months. I understand that this authorization may be revoked at any time, except to the extent that action has been taken in reliance on this authorization. Unless otherwise revoked, this authorization will expire in ninety (90) days from the date below.

I understand and agree to pay a reasonable copying fee to cover the cost of transfer. I further understand that I may refuse to sign this authorization and that my refusal to sign will not affect my ability to obtain treatment or payment or my eligibility for benefits. I may inspect or copy any information to be used or disclosed under this authorization. I understand that Provider's records may contain information created by an entity other than **Midwest Occupational Medicine, Ltd** and therefore is not responsible for the information contained in such incorporated information (including the accuracy, completeness, relevance, legibility or lack thereof of such incorporated records). I expressly request release of all records maintained by **Midwest Occupational Medicine, Ltd** concerning me, including incorporated records. I acknowledge that **Midwest Occupational Medicine, Ltd** has no and assumes no duty to me regarding the content of or omissions from such incorporated records.

I hereby release **Midwest Occupational Medicine, Ltd** and its personnel from all legal responsibility of liability that may arise from the act I have authorized above. **Midwest Occupational Medicine Ltd** is not responsible for completeness, legibility, or omissions caused by the copying of any medical records from another institution.

_____ _____
Signature of patient or patient's representative **Date**

Printed name of patient's representative_____
Relationship to patient_____

Prohibition on redisclosure: This information, which has been disclosed to you from confidential records, is protected by federal law. Federal regulations prohibit you from making any further disclosure of this information except with the specific written authorization of the person to whom it pertains. A general authorization for the release of medical or other information if held by another party is not sufficient for this purpose. Federal regulations state that any person who violates any provision of this law shall be fined or imprisoned.

IMPORTANT: Please fully complete your form, save the file to your computer, and email your completed form to the emails listed at the top of midwestoccmed.com/forms.