Ronald E. Palmer, M.D.
Mark R. Phillips, M.D.
James W. Maxey, M.D.
Brian Ted Maurer, M.D.
Gregory J. Adamson, M.D.

Richard P. Driessnack, M.D.
Jeffrey R. Garst, M.D.
Stephen R. Orlevitch, M.D.
Steven K. Below, M.D.
Piero Capecci, M.D.
Bernard R. Cahill, M.D. Emeritus

AUTHORIZATION FOR RELEASE OF HEALTH INFORMATION

I, the undersigned, authorize Great Plains Orthopaedics to release information

to: ____
(Name of physician, agency, facility, or party records are to be disclosed to)

____
(Address of physician, agency, facility, or party records are to be disclosed to)

____

regarding: ____ ______________________
(Full name of patient) (Date of birth of patient)

Dates of Service: ___________________________

For the purpose of: ____

I authorize release of the following information:

- ☐ Psychiatric information
- ☐ Alcohol and Drug Abuse information
- ☐ HIV/AIDS information
- ☐ Genetic information

The following information is requested:

- ☐ Progress Notes
- ☐ Report of Operation
- ☐ History and Physical
- ☐ Complete Record
- ☐ Lab Reports
- ☐ X-ray Reports
- ☐ Therapy Records
- ☐ X-ray films
- ☐ Other _______________

I understand that I have the right to revoke this consent by written statement at any time, otherwise it will automatically expire 90 days from the date of this authorization. Information released prior to any revocation is not affected.

I further understand that once my protected health information leaves the control of Great Plains Orthopaedics, it may be further disclosed by the receiving party. I agree that I will not hold Great Plains Orthopaedics liable for re-disclosures of the health information I have authorized that are made by the individual or entity named in this authorization.

____ ______________________
(Signature of Patient or Authorized Representative) **(Date)**

____
(Relationship to Patient)

303 North Kumpf Boulevard Peoria, Illinois 61605 309-676-5546 FAX 309-676-5045