TRI-STATE SPECIALISTS

ORTHOPAEDIC SURGERY
DERMATOLOGY
GENERAL SURGERY
PLASTIC SURGERY

Main Office
2730 Pierce Street - Suite 300 • Sioux City, IA 51104
Phone (712) 224-8677 • Fax (712) 277-1662

Physical Therapy
2730 Pierce Street - Suite 203 • Sioux City, IA 51104
Phone (712) 224-8677 • Fax (712) 277-1662

MRI Services
2730 Pierce Street - Suite B11 • Sioux City, IA 51104
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PATIENT'S AUTHORIZATION FOR RELEASE OF INFORMATION

Name of Patient: ______________________________

Maiden or Previous Name(s): ______________________________

Phone Number: ______________________________

Date of Birth: ______________ Social Security Number: ______________

Records to Include:

_____Aaron Althaus, MD	_____Joseph Morris, MD	_____Adam Smith, MD
_____Michael Doarn, MD	_____Phinit Phisitkul, MD	_____Walker Wynkoop, MD
_____Leonel Herrera, MD	_____William Samuelson, MD	_____Gary Tillman, CRNA
_____Kevin Liudahl, MD	_____Ruslan Safarov, MD	_____Other____________
_____Raymond Kuwahara, MD		

I herby authorize and request that my medical records be handled in the following manner:

___Release Medical Records ___Obtain Medical Records

___Release X-Rays/Imaging Body Part____________ ___Obtain X-Rays/Imaging Body Part____________

To or from the following:

Name: ______________________________

Address: ______________________________

Phone: ______________________Fax: ______________________

(Insert names and addresses of doctors, hospitals, institutions, etc.)

_____ Any and all information from my chart

OR

_____ Any and all information EXCEPT substance abuse (drug or alcohol) mental health, and AIDS-related information to be released

OR

_____ ONLY the following information______________________

This Authorization is effective for 12 months (OR _____months) after the date it is signed. 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 health care provider or record keeper.

A photocopy or exact reproduction of this signed Authorization shall have the same force and effect as the original.
I hereby authorize the release of information as indicated above.

______________________________ ______________________
Signature of Patient or Legal Guardian Date of Signing

______________________________ ______________________
Relationship, if NOT the Patient Date of Signing