ILLINOIS
BONE & JOINT
INSTITUTE®
Move better. Live better.

Authorization to Disclose/Release Protected Health Information

(Must be signed by patient or legal representative before medical records will be released)

Patient Name: _____ **Date of Birth:** _____ Phone: _____

Address: _____ City/State: _____ Zip Code: _____

I authorize Illinois Bone and Joint Institute Medical Records Department to use/disclose a copy of the specified protected health information as indicated below to (Recipient):

Recipient: Name:_____ Phone: _____ Fax: _____

Address: _____ City: _____ State: _____ Zip Code: _____

☐ Send the entire medical record (all information) to the above named recipient.

☐ Send only the following information to the above named recipient: _____

_____

Records for the period (dates) from: _____ to _____

Purpose or need for information: ☐ Continuation of care ☐ Personal use ☐ Other/Describe: _____

I understand that if this information is emailed per my request, there may be some level of risk that this information could be read by an unauthorized third party.

I must check one or more of the following types of health information that I do NOT want released to the above recipient. I understand that if I do NOT check any of the four (4) boxes below, the health information released to the Recipient may include:

☐☐HIV/AIDS related information/records ☐☐ Genetic testing information/records

☐☐Mental health information/records ☐☐ Drug/alcohol diagnosis, treatment or referral

I understand that if the person or entity that receives the above information is not a healthcare provider or health entity covered by federal privacy regulations, the information described above may be re-disclosed and no longer protected by these regulations. However, the recipient may be prohibited from disclosing substance abuse information under the Federal Substance Abuse Confidentiality Requirements.

I understand that I may refuse to sign this authorization and that my refusal will in no way affect my ability to obtain treatment or payment or my eligibility for benefits. I may inspect or receive a copy of any information used/disclosed under this authorization.

I understand that I may revoke this authorization at any time, provided that I do so in writing, except in the instance that action has already been taken in reliance upon this authorization. Unless revoked earlier, this authorization: ☐ is a 1-time request ☐☐ expires in 30 days ☐ ☐ expires in _____ days.
Unless otherwise specified, this form expires one year from date of signature.

Signature of Patient or Patient's Legal Representative: _____ Date: _____

Print Name of Legal Representative: _____ Relationship: _____

P#_____

OrthoHealth
A Metabolic Approach to an Active Lifestyle
by Illinois Bone & Joint Institute

OrthoHealth Global Health Assessment

Promis10 Questionnaire

	Excellent	Very Good	Good	Fair	Poor
In general, would you say your health is? (G1)	5	4	3	2	1
In general, would you say your quality of life is? (G2)	5	4	3	2	1
In general, how would your rate your physical health? (G3)	5	4	3	2	1
In general, how would your rate your mental health, including your mood and your ability to think? (G4)	5	4	3	2	1
In general, how would your rate your satisfaction with your social activities and relationships? (G5)	5	4	3	2	1
In general, please rate how well you carry out your usual social activities and roles. (This includes activities at home, at work, and in your community, and responsibilities as a parent, child, spouse, employee, friend, etc) (G9)	5	4	3	2	1

	Completely	Mostly	Moderately	A Little	Not At All
To what extent are you able to carry out your everyday physical activities such as walking, climbing stairs, carrying groceries, or moving a chair? (G6)	5	4	3	2	1

In the past 7 days?	Never	Rarely	Sometimes	Often	Always
How often have you been bothered by emotional problems such as feeling anxious, depressed, or irritable?(G10)	5	4	3	2	1

In the past 7 days?	None	Mild	Moderate	Severe	Very Severe
How would you rate your fatigue on average? (G8)	5	4	3	2	1

In the past 7 days?	No Pain										Worst Pain
How would you rate your pain on average?(G7)	0	1	2	3	4	5	6	7	8	9	10

P#_____

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Sleep Quality Assessment

During the past month,	Less than 15 mins	16 - 30 mins	31 - 60 mins	More than 60 mins
How long (in minutes) has it taken you to fall asleep each night?	0	1	2	3

	More than 7 Hours	6 - 7 Hours	5 - 6 Hours	Less than 5 Hours
How many hours of actual sleep did you get at night?	0	1	2	3
How many hours were you in bed?	0	1	2	3

During the past month, how often have you had trouble sleeping because you;	Not During Past Month	Less than once a week	Once or Twice a week	Three or More times a week
Cannot get to sleep within 30 mins	0	1	2	3
Wake up in middle of night or early morning	0	1	2	3
Have to get up to use bathroom	0	1	2	3
Cannot breath comfortably	0	1	2	3
Cough or snore loudly	0	1	2	3
Feel too cold	0	1	2	3
Feel too hot	0	1	2	3
Have bad dreams	0	1	2	3
Have pain	0	1	2	3
Other , reason(s), please describe, including how often you have had trouble sleeping because of this reason(s)				
	0	1	2	3
In the past month,				
How often have you taken medicine (over the counter or prescribed) to help you sleep?	0	1	2	3
How often have you had trouble staying awake while driving, eating meals, or engaging in social activities?	0	1	2	3
How much of a problem has it been for you to keep up enthusiasm to get things done?	0	1	2	3

	Very Good	Fairly Good	Fairly Bad	Very Bad
During the past month, how would you rate your sleep quality overall?	0	1	2	3