ORTHOPAEDIC SURGERY CENTER

AUTHORIZATION TO RELEASE HEALTH INFORMATION

I, _____, authorize the Orthopaedic Surgery Center to release the health/medical information of:

Patient's Full Name	*Date of birth*
Patient's Address	*Phone number*

This information is to be released to: ☐ Mail ☐ Fax ☐ pick-up _____

Name:	Phone #:
Address:	Fax #:

For the purpose of: _____

Covering records from the following **date(s) of service**: _____

This release includes specifically:

☐ Complete Record	☐ Nursing assessment	☐ Laboratory Results
☐ Physician's Orders	☐ History & Physical	☐ EKG
☐ Lab/Testing Reports	☐ Operative Report	☐ Other _____

I understand that my permission to release this information to the following party/ies will include sensitive clinical information obtained during the dates listed below. To exclude the disclosure of this information, initial the information that shall be excluded.

____alcohol/drug abuse	_____ mental Health/Psychiatric information
____HIV testing or diagnosis	_____ sexually transmitted diseases

I understand this authorization may be revoked in writing at any time, except to the extent that action has been taken in reliance on this authorization. Unless otherwise revoked, this authorization will expire 12 months from date of signature. I understand that Orthopaedic Surgery Center will not condition my treatment on whether I provide authorization for the requested use or disclosure.

Signature: _____

Person authorizing release	*Date*

Relationship to patient: _____

Office Use Only:

☐ Guardianship paperwork ☐ Durable Power of Attorney for Healthcare paperwork ☐ other_____☐ n/a

Authorization Received: ☐ in-person ☐ via mail/fax on (date): _____

Identity verified by _____date sent: _____☐ Mail ☐ Fax ☐ pick-up

☐ photo ID ☐ SRS photo or ☐ signature on consent, DOB, DOS, address, and phone number