PATIENT NAME	LAST	FIRST	MI
DATE OF BIRTH		SOCIAL SECURITY NUMBER	
ADDRESS			
CITY		STATE	ZIP
PHONE		HISTORY NUMBER	OFFICE USE
DESCRIPTION OF INFORMATION TO BE RELEASED OR TREATMENT DATES			

PURPOSE OF AUTHORIZED DISCLOSURE

□ Continuity of Care □ Patient Request □ Social Security
□ Insurance Claim □ Worker's Comp. □ Employer Request
□ Attorney Inquiry □ Other : _____

METHOD

□ USB Drive □ Email
□ CD □ Paper

Released by:

(initials)

RELEASE TO PERSON/ORGANIZATION		
ADDRESS		
CITY	STATE	ZIP
EMAIL		FAX

INFORMATION TO BE RELEASED

□ **PERTINENT SUMMARY (includes all * items if contained in record)**

□*Face Sheet □*Consult □*Radiology Report □ Office Visit Note □*EKG Report
□*Discharge Summary □ *Pathology Report □*Lab Report □ PT/OT □ Entire Chart
□*History & Physical □*Operative Report □ Radiology Images □ Scope Images
□ Other : _____

I the undersigned, authorize _____ (Disclosing Institution) and its employees to release information from my medical records as described above. I understand and acknowledge that the medical record may contain information regarding psychiatric disorders, Human Immune Virus (HIV) test results, Acquired Immune Deficiency Syndrome (AIDS), AIDS-related conditions, alcohol, and/or drug dependence/abuse and authorize the release of the same pursuant to this authorization.

I also understand that information used or disclosed according to this authorization may be subject to re-disclosure by the recipient and may no longer be protected.

My failure to thoroughly complete and sign this authorization may result in my information not being released.

This authorization for release of information is valid for 60 days from date of signature, unless revoked by me through written notice, provided the said notice of revocation is received prior to release of information. If you need assistance in revoking this authorization, please contact the Health Information Management-Medical Records Department directly.

I understand that treatment, payment, enrollment, or eligibility for benefits will not be conditioned on my failure to sign this authorization.

SIGNATURE OF PATIENT (OR REPRESENTATIVE)** DATE

□ Parent/Guardian □ POA
□ Executor □ Person Responsible for Estate

** If other than patient's signature, a copy of legal documents MUST accompany the authorization when presented, the exception is a parent of minor under 18 years of age.

♦Please be advised that a fee for records will be assessed in accordance with ORC 3701.741

PATIENT LABEL

CRYSTAL CLINIC
ORTHOPAEDIC CENTER

60130200 0224

AUTHORIZATION FOR THE RELEASE OF MEDICAL INFORMATION