

PATIENT NAME	LAST	FIRST	MI
DATE OF BIRTH	LAST 4 DIGITS OF SSN		
ADDRESS			
CITY	STATE	ZIP	
PHONE	HISTORY NUMBER	OFFICE USE	
DESCRIPTION OF INFORMATION TO BE RELEASED AND/OR TREATMENT DATE/RANGE			

PURPOSE OF AUTHORIZED DISCLOSURE

- Continuity of Care
- Insurance Claim
- Legal/Litigation
- Patient Request
- Worker's Comp.
- Other : _____
- Social Security
- Employer Request

METHOD

- USB Drive Email
- CD Paper
- Patient Portal

Released by:
(initials)

Only the information specifically described above will be released. If "entire medical record" is selected, this includes records maintained by Crystal Clinic Orthopaedic Center and any affiliates as part of the patient's designated record set.

RELEASE TO PERSON/ORGANIZATION			
ADDRESS			
CITY	STATE	ZIP	
EMAIL		PHONE	
		FAX	

INFORMATION TO BE RELEASED

<input type="checkbox"/> PERTINENT SUMMARY (includes all * items if contained in record)				
<input type="checkbox"/> *Face Sheet	<input type="checkbox"/> *Consult	<input type="checkbox"/> *Radiology Report	<input type="checkbox"/> *Office Visit Note	<input type="checkbox"/> *EKG Report
<input type="checkbox"/> *Discharge Summary	<input type="checkbox"/> *Pathology Report	<input type="checkbox"/> *Lab Report	<input type="checkbox"/> PT/OT	<input type="checkbox"/> Entire Chart
<input type="checkbox"/> *History & Physical	<input type="checkbox"/> *Operative Report	<input type="checkbox"/> Radiology Images	<input type="checkbox"/> Scope Images	<input type="checkbox"/> Billing Records
<input type="checkbox"/> Other : _____				

I the undersigned, authorize _____ (Disclosing Institution) and its employees to release information from my medical records as described above. I understand my medical record may contain sensitive information, including mental health information, substance use disorder treatment information, HIV/AIDS or other communicable disease information, or genetic testing information, and I authorize the release of such information as permitted by applicable law.

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.

This authorization will expire one (1) year from the date of signature unless revoked earlier by me in writing. This authorization applies only to information contained in the medical record as of the date this authorization is signed. Any records created after the date of signature must be accompanied by a new authorization. If the patient is deceased after signature, the authorization remains valid, but may require validation of the requestor's legal authority.

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 Ohio Revised Code 3701.741

PATIENT LABEL

