



AUTHORIZATION FOR RELEASE OF MEDICAL INFORMATION

I, _____
Patient Name (Please Print) Date of Birth

Address: _____
(Street) (City/State) Zip

Day Time Phone: () _____ S.S.# _____

Hereby authorize Orthopedic Specialists, S.C. to release copies of my medical records to the following:

REQUESTOR: _____

ADDRESS: _____

REASON FOR RELEASE:

___ Change in Insurance ___ Moving ___ Changing Doctors/Leaving Practice

The following records will be released unless checked by patient:

___ Alcohol and/or Drug Dependency ___ HIV/AIDS Antibody test results and diagnosis treatment records

___ Mental health treatment records Other _____

I understand that only the last 5 years of physician's notes, x-ray reports and diagnostic test results will be released as well as the last year of laboratory results, unless otherwise indicated below:

Prohibition or Re-disclosure: This information has been given to you from confidential records. You are prohibited from making disclosure of this information except with the specific written consent of the person to whom it pertains and the facility for which the information originates.

Signature of patient or authorized representative Date

THE RELEASE OF THIS INFORMATION WILL BE SUBJECT TO A CHARGE