AUTHORIZATION FOR RELEASE OF MEDICAL INFORMATION

Patient Name: ________________________________ Date of Birth: __________

Phone Number: ________________________

☐ I hereby authorize Orthopedic Associates of 65 Pennsylvania Avenue, P.C. to release information to:

Name of Provider/Facility ____

Address ____

Contact Person ___________ Telephone ___________ Fax Number: ______________

☐ I will pick up the records __________ (please allow 5 business days) (pick-up date) ☐ Please mail the records to the address above. (X-rays & MRIs are not mailed and will need to be picked up)

☐ I hereby authorize the above to release information TO Orthopedic Associates / 65 Pennsylvania Avenue / Binghamton NY 13903 (607) 723-5393.

The PURPOSE of this request is (check all that apply)

☐ My ongoing care ☐ Insurance matter ☐ Transferring care / moving

☐ Second opinion ☐ Personal ($.75 per sheet) ☐ Other ___________________

Please forward:

☐ Information pertaining specifically to: ___________________________________

please note body part (s)

- ☐ Office Notes _______________
- ☐ Operative Report _____________ ☐ copy of req to MedRec
- ☐ X-Rays / note the last year you were x-rayed here: __________ ☐ copy of request to X-ray
- ☐ MRI ______________________ ☐ copy of request to MRI

This authorization applies to the records for treatment received on or prior to the date of this authorization. Authorization is VALID for this request only and authorization will expire upon completion of this request.

I understand that this authorization gives Orthopedic Associates, P.C. permission to use and /or disclose health information about me. I may revoke this authorization at any time by submitting a written request to Orthopedic Associates, P.C. except where a disclosure has already been made in reliance on my prior authorization. I understand that the above information may include HIV, psychiatric/mental health, substance abuse diagnoses and require additional authorization. I understand there may be a charge for my records. I may request a copy of this authorization form at no charge.

SIGNATURE OF PATIENT or Authorized Representative: _______________________

Print Name of Authorized Representative: ____________________________

Address / phone # of Authorized Rep.: _______________________________

Request received by: ______________ Date: __________ Requested processed by: ______________ Date: ________