CONSENT FORM for RELEASE OF MEDICAL INFORMATION

James S. Martin, M.D.
John C. Sefter, D.O.
Brian A. Spencer, D.O.
Paul V. Suhey, D.O.
1700 Old Gatesburg Rd. #200
State College, PA 16803
Office: 814-237-4321 Fax: 814-235-0484

Patient Name:			
Patient Address:	City:	State:	Zip Code:
DOB:	Social Security #:		

☐ **Release Patient Records TO:**
Martin & Suhey Orthopedics, P.C.
1700 Old Gatesburg Road, Suite 200
State College, PA 16803
or Fax: 814-235-0484

From:

OR

☐ **Release Patient Records FROM**
Martin & Suhey Orthopedics

To:

Release Purpose:

Medical Records Copies Requested
May include but not limited to

Office Visit Notes: ☐	Past Medical History: ☐	Correspondence from other physicians: ☐
Operative Report: ☐	Work/Disability Status: ☐	Physical Therapy Reports: ☐
Lab Results: ☐	Treatment Plan: ☐	School/Event Participation Status: ☐
X-ray File/Reports: ☐	Current Diagnosis: ☐	Other:

THE FOLLOWING INFORMATION IS PROTECTED BY STATE AND FEDERAL LAW
Please *initial each box* indicating you are aware this information may be released.

HIV (act 148) ☐ init	Alcohol or Drug Abuse ☐ init	Psychiatric ☐ init

Authorization Period

This authorization shall be valid from	Effective Date (Today):
	Ending Date:

I understand that this consent may be revoked by me, in writing, at any time, except to the extent that action has been taken in reliance upon it. I also acknowledge the information disclosed pursuant to this authorization may be subject to re-disclosure by the recipient and no longer protected by federal law.

PATIENT'S SIGNATURE:	Date:

IF A PATIENT IS UNABLE TO SIGN CONSENT OR IS A MINOR, COMPLETE THE FOLLOWING

Patient is a minor:	☐		Year of Age:
Patient unable to sign consent:	☐		Reason:
Signature of Parent/Legal Representative:			Date:

Relationship: ☐ Parent ☐ Legal Guardian ☐ Other