



AUTHORIZATION FOR RELEASE OF INFORMATION

I hereby authorize the use or disclosure of my individually identifiable health information as described below. I understand this authorization is voluntary. I understand that if the organization authorized to receive the information is not a health plan or health care provider, the released information may no longer be protected by federal privacy regulations, and that it may be re-disclosed by the recipient.

Patient Name: _____ Date of Birth: _____
Phone # _____

Organization Providing the Information: _____
Address: _____

Organization(s) or Person(s) Receiving the Information: _____

Specific Description of Information Disclosed: Complete Medical Record Progress Notes
 Imaging/Lab Reports X-Rays Other _____

To the extent any of the following information is contained in my records being released, I specifically authorize the release of such information for the purposes indicated below by initialing before each category:

- Initials: HIV/AIDS testing, test results, treatment and related information including high risk behavior documented;
- Initials: drug and/or alcohol diagnosis, treatment, test results and reports and referral information;
- Initials: mental health treatment information, test results and reports including psychological and psychiatric studies, reports, evaluations and referral information; and/or
- Initials: venereal disease information;
- Initials: genetic testing, test results, counseling, reports, treatment, and referral information.

Purpose of Disclosure: Moving Out of Area Disability Application Insurance Request
 Patient Access Choosing a New Physician Other _____

You must read and initial the following statements:

1. I understand this Authorization will expire 7 YEARS FROM DATE OF SIGNATURE or on the following event: Termination of the Physician/Patient Relationship. Initials: INITIAL HERE
2. I understand that I may revoke this Authorization at any time by notifying Martin & Suhey Orthopedics Privacy Officer in writing, but if I do, it will not have any effect on any actions Martin & Suhey Orthopedics ("MSO") took before they received the revocation. Initials: INITIAL HERE

This Authorization will NOT be accepted unless it is completed in its entirety.

Signature of Patient or Representative SIGN HERE _____
Last Four Digits Patient SS#

Patient Phone # _____

Relationship to Patient Date _____

You may refuse to sign this Authorization. We cannot condition treatment on your signing this Authorization.

Patient Received on(date): _____ Patient Initials INITIAL HERE MSO Initials TTN _____

Pick Up: _____ Mail To: (or Fax To) _____

Route To: Medical Records Billing X-Ray

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