COMMUNITY ORTHOPEDIC MEDICAL GROUP

Orthopedic Specialists

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AUTHORIZATION FOR USE AND DISCLOSURE OF MEDICAL INFORMATION

This authorization allows the healthcare provider(s) named below to release confidential medical information and records. Note: *Information and records regarding treatment of minors, HIV, psychiatric/mental health conditions, or alcohol/substance abuse have special rules that require specific authorization*.

Date:____________________________ Medical Record#:______________________ (For office use)

Patient Name (Please print):__________________________ ,______________________________
Last Name First Name

Address:____

Date of Birth:_____________________ Telephone Number:_______________________________

AUTHORIZATION:
I hereby authorize **COMMUNITY ORTHOPEDIC MEDICAL GROUP** to release a copy of my health information to the person/organization specified below:

❑Call when copies are ready to be picked up. Phone#:___________________________________
❑Mail to the address listed below
❑Will pick up on: _________ ❑Fax to:________________ ❑Email to:______________________

To: ____
Name
____
Address
____ ______________ _________________
City State Zip Code

Release information regarding:

- ❑ All Medical Records
- ❑ Progress Notes
- ❑ Lab Test Reports
- ❑ Physical Therapy Reports
- ❑ Surgery Reports
- ❑ Other (Specify):____
- ❑ Radiology Reports (MRI, CT Scan, X-ray, Dexa Scan, EMG)
- ❑ Radiology Film/CDs (X-ray, CT, MRI)

***CD is not compatible & cannot be opened by MAC computers**

WE DO CHARGE A $35.00 FEE IF ALL RECORDS ARE REQUESTED
PLEASE ALLOW 48 HOURS TO PROCESS YOUR REQUEST

Patient Name (Please print):___________________________ ,______________________________
Last Name First Name

**The medical information/records will be used for the following purpose:

____

**If moving, please provide new mailing address:

____

____

This authorization is:
[ ] Unlimited (all records, excluding Substance Abuse, Mental Health, HIV Diagnosis/ Treatment
[ ] Limited to the following medical information:__________________________________

I also consent to the specific release of the following records:

Drug/Alcohol/Substance Abuse	______(initial)	HIV Diagnosis/Treatment	______(initial)
Psychiatric/Mental Health	______(initial)	Genetic Information	______(initial)
Tests for Antibodies to HIV	______(initial)		

DURATION:
This authorization shall be effective immediately and remain in effect until ____________________
DATE

RESTRICTIONS:
Permissions for further use or disclosure of this medical information is not granted unless another authorization is obtained from me or unless such disclosure is specifically required or permitted by law.

I have been advised of my right to receive a copy of this authorization.

____ ______________________________
Signature of Patient or Patient's Representative Date

____
Print Name and Relationship to Patient

OFFICE USE ONLY

Completed by:______________________________________ **Date:**_________________________

PAYMENT OF $_______DUE UPON RECEIPT OF MEDICAL RECORDS

Collected by:_______________ Date received_______________ by__________

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