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Medical Records Release and Authorization for Use or Disclosure of Protected Health Information

Please complete the following information:

Patient Name: _____

Email address to whom records are to be sent: _____

Date of Birth: ____/____/____ Physician: _____

I authorize The Central Orthopedic Group to disclose/release the following information * (check all applicable):

For Dates of Service: From: _____ Through: _____

- | | |
|--|---|
| <input type="checkbox"/> All Orthopedic Exam notes. | <input type="checkbox"/> X-rays images on a CD (\$25.00 fee per disk) |
| <input type="checkbox"/> MRI reports/diagnostic testing. | <input type="checkbox"/> MRI images on a CD. (\$25.00 fee per disk) |
| <input type="checkbox"/> Operative reports. | <input type="checkbox"/> Billing ledger. |
| <input type="checkbox"/> Worker's Compensation (C4) forms. | |

****Please allow one week for processing.**

I understand that after the custodian of records discloses my health information, it may no longer be protected by federal privacy laws. I further understand that this authorization is voluntary and that I may refuse to sign this authorization. My refusal to sign will not affect my ability to obtain treatment; receive payment; or eligibility for benefits unless allowed by law. By signing below I represent and warrant that I have authority to sign this document and authorize the use or disclosure of protected health information and that there are no claims or orders pending or in effect that would prohibit, limit, or otherwise restrict my ability to authorize the use or disclosure of this protected health information.

***Note: If these records contain any information from previous providers or information about HIV/AIDS status, cancer diagnosis, drug/alcohol abuse, or sexually transmitted disease, you are hereby authorizing disclosure of this information.**

Signature of patient (or patient's
personal representative)

Date

Printed name of patient representative