Ortho*Neuro*

For every motion in life.

Authorization for Disclosure of Health Information

PLEASE FAX TO: MEDICAL RECORDS 614-818-7724

I hereby authorize: ___________________________________ to release medical information from the records of

Patient's Name: __________________________________ **D.O.B.:** _____/_____/______ SS#: _____-_____-______

Patient's Street Address: ____

City: __________________________ **State:** ______________ **Zip Code:** __________________

Date(s) of Treatment Requested: ____

Information to be disclosed (check all applicable items to be released):

☐ ER Record ☐Progress Note ☐Treatment Plans ☐EKG/ECG ☐Consultations ☐Therapy Notes
☐ X-Rays Reports ☐Medication Records ☐History & Physical ☐Lab Reports ☐Tests ☐Operative Reports
☐ Other (please specify):____

Purpose Or Need For The Disclosure Is:

☐Continued Medical Care ☐Insurance ☐Legal ☐Patient's Own Use ☐Other_____________________________

The Information May Be Disclosed To:

Recipient's Name: ____

Street Address: ____

City: ______________________________________ State: __________________ Zip Code:___________

Phone #:___________________________________ Fax: _______________________________________

My refusal to sign this form will not adversely affect my ability to receive health care services, reimbursement for services enrollment in a health plan or my eligibility for health benefits. However, information will not be released to the above indicated recipient without my signature.

I acknowledge that the information disclosed pursuant to this authorization may be subject to re-disclosure by the recipient and no longer protected by Federal Law.

I have the right to revoke this authorization by written notice to the Healthcare Provider listed above. I understand that actions taken in reliance on this authorization cannot be reversed, and my revocation will not affect those actions.

This authorization expires on: ________________________ or upon the following event: ________________________
(Date)
(If no date or event is specified, this authorization will expire in 60 days from the date of signature).

I understand that the information in my medical record may include information relating to treatment of drug or alcohol abuse, mental health, sexually transmitted disease, acquired immunodeficiency syndrome (AIDS), AIDS related complex (ARC) and/or human immunodeficiency virus (HIV).

Fees: I understand and agree that there may be costs associated with this request in compliance with State copying laws.

____ ______________________________
(Signature of Patient or Personal Representative*) (Date of Signature)

***If signed by a personal representative, a description of the representative's authority to act is as follows:**

☐Parent ☐Legal Guardian ☐Health Care Power of Attorney
☐Administrator ☐Executor of Estate ☐Next of Kin ☐Beneficiary