Doctor#___________
Chart#____________

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
__ Operative Reports __ Imaging/Lab Reports __X-Rays ___ Other ______________________________

To the extent any of the following information is contained in my records being released,
<u>I specifically authorize the release of such information</u> 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: <u>Termination of the Physician/Patient Relationship.</u> **Initials:**

2. I understand that I may revoke this Authorization at any time by notifying Orthopedic Institute of Pennsylvania's Privacy Officer in writing, but if I do, it will not have any effect on any actions Orthopedic Institute of Pennsylvania took before they received the revocation. **Initials**: ______

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

____
Signature of Patient or Representative 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 ______ OIP Initials________
Pick Up:_____ Mail To:________
Route To: ____Medical Records ____Billing ____X-Ray Revised 3/6/07