Account # _____ Doctor _____

☐ Disability ☐ HMG

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 release 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_____

Information to be Disclosed: Complete Medical Record _____ Other _____

Purpose of Disclosure: _____ Patient Access _____ Disability/Insurance ____Other

Release the Information to: _____

Choose how this information will be released:

Mail to: _____ Fax to: _____

Pick up: _____ Form completion is $10 per form. Paid: Yes _____ No _____

PLEASE ALLOW 7-10 BUSINESS DAYS FOR FORMS COMPLETION

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

♦ Drug and/or Alcohol diagnosis, treatment, test results and reports and referral information
♦ Mental health treatment information, test results and reports including psychological and psychiatric studies, reports,
Initials: evaluations and referral information and/or
_____ ♦ Venereal Disease information or Genetic testing, test results, counseling, reports, treatment, and referral information.

You must read and initial the following statements:

Initials: _____ ♦ I understand this Authorization will expire 7 YEARS FROM THE DATE OF SIGNATURE or on the following event: Termination of the Physician/Patient Relationship.

Initials: _____ ♦ 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.

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 your treatment on your signing this Authorization.

OIP 3399 Trindle Road Camp Hill, Pa 17011 Fax: 717-737-7197 Phone: 717-761-5530