

ROBINWOOD ORTHOPAEDIC SPECIALISTS
AUTHORIZATION FOR RELEASE OF MEDICAL INFORMATION

(Print patients full name)

Birth Date (Mo/Day/Yr)

(Street address)

Social Security Number

(City, state, zip code)

Phone (Home)

At the request of the individual, I _____, do hereby authorize _____ to release:
(patient's name) (name of facility)

- | | | |
|---|---|--|
| <input type="checkbox"/> Discharge Summary | <input type="checkbox"/> Pathology Reports | <input type="checkbox"/> Emergency Reports |
| <input type="checkbox"/> History & Physical | <input type="checkbox"/> Laboratory Reports | <input type="checkbox"/> Physical Therapy |
| <input type="checkbox"/> Progress Notes | <input type="checkbox"/> Radiology Reports | <input type="checkbox"/> Other |
| <input type="checkbox"/> Operative Notes | <input type="checkbox"/> ECG/EEG/Cardiac Cath | _____ |
| | | _____ |

INFORMATION RELEASE TO:

Name of Company/Agency/Facility/Person

Street Address

City, State, Zip

PURPOSE OF DISCLOSURE:

- | | | | |
|---|---|---------------------------------------|---|
| <input type="checkbox"/> Referral to Specialist | <input type="checkbox"/> Insurance | <input type="checkbox"/> Workers Comp | <input type="checkbox"/> Change of Doctor |
| <input type="checkbox"/> Legal Investigation | <input type="checkbox"/> Disability Determination | <input type="checkbox"/> Personal | <input type="checkbox"/> Continuing Care |
| Other (Specify) _____ | | | |

Please provide current telephone number in the event we need to contact you: _____

I hereby authorize disclosure of the health information for the above named patient. The information authorized for release may include records which may indicate the presence of a communicable or venereal disease which may include, but are not limited to, diseases such as hepatitis, syphilis, gonorrhea and the human immunodeficiency virus, also know as AIDS. Records may also include information concerning drug/alcohol use, mental health etc. This authorization is valid for 12 months from the date of signature. I understand that I may cancel this request with written notification but that it will not effect any information released prior to notification of cancellation. I understand that the information used or disclosed may be subject to re-disclosure by the persons or facility receiving it, and would then no longer be protected by federal regulations. I understand that the medical provider to whom this is furnished may not condition its treatment of me on whether or not I sign the authorization.

**Signature of individual or guardian or
Personal Representative of patient's care** **Date**

Witness Signature **Date**

Note: MD State Laws permits a fee to be charged for the copying of patient records.