STEVENS POINT ORTHOPEDICS

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World Class Treatment…Hometown Care

Authorization to Release Medical Records

I, the undersigned, authorize the release of, or request access to the information specified below from the medical record(s) to the below-named individual or entity.

Name of Individual/Entity: _____ Phone: _____
Street Address: _____ Fax: _____
City/State/Zip Code: _____

INFORMATION TO BE RELEASED OR ACCESSED:

☐ Disclosure of Health Information covering the period of care from:
  ☐ (Specific Dates:) _____ to _____ **OR** All Dates
☐ Disclosure of Health Information in regard to treatment of (list specific body part(s)): _____

☐ Medical History/Exam Reports	☐ Physical Therapy Notes	☐ Imaging Studies
☐ Medication List	☐ Surgical Reports	☐ All
☐ Allergy List	☐ X-Ray/Imaging Reports	☐ Specific Body Part:
☐ Laboratory Reports	☐ Billing Statement	_____
☐ Other: _____		

PATIENT INFORMATION IS NEEDED FOR:

☐ Continuity of Care	☐ Insurance Request	☐ Request of the Patient
☐ Disability/FMLA	☐ Legal	☐ Workers Compensation Request
☐ Other: _____		

I understand that my records are confidential and cannot be disclosed without my written authorization, except when otherwise permitted by law. Information used or disclosed pursuant to this authorization may be subject to redisclosure by the recipient and no longer protected. I understand that the specified information to be released may include but is not limited to history, diagnoses, and/or treatment of drug or alcohol abuse, mental illness, or communicable disease, including HIV and AIDS.

I understand that my treatment or payment for my treatment cannot be conditioned on the signing of this authorization. I also understand that I may revoke this authorization in writing at any time except to the extent that action has been taken in reliance upon the authorization.

This authorization will remain in effect for one year from date of signature.

Patient Name: _____ _____
Address: _____ **Signature of Patient or Legal Representative**
City/State/Zip Code: _____ _____
Date of Birth: _____ **Relationship to Patient**
Phone: _____ **Date**: _____