AUTHORIZATION FOR RELEASE OF INFORMATION

PATIENT INFORMATION:

_______________________________________ DOB____________ SS#___________
(**PRINT** name of patient. Include AKA's)

INFORMATION TO BE RELEASED **FROM**:	INFORMATION TO BE SENT **TO**:
(Name of designated facility or provider)	(Name of designated facility or provider)
(address)	(address)
(city, state, zip)	(city, state, zip)

INFORMATION TO BE RELEASED:

- ❒ The most recent 2yrs of pertinent information (chart notes, labs, x-ray and special tests)
- ❒ All medical records
- ❒ All records from ___________ to ___________
- ❒ Films (specify dates/views) ________________________
- ❒ Other (specify) ____

PURPOSE FOR WHICH DISCLOSURE IS BEING MADE: (check one of the following)

❒Referral ❒Moving ❒Legal ❒Insurance ❒Other ___________________

PATIENT AUTHORIZATION:

I understand that my records **may** contain information regarding the diagnosis or treatment of HIV/AIDS, sexually transmitted diseases, drug and or alcohol abuse, mental illness, or psychiatric treatment. I give my specific authorization for these records to be released.

I would like to **EXCLUDE** the following information, which may or may not be contained within my chart, from release***. (please initial)***

___ Drug/alcohol abuse treatment & diagnosis ___ Sexually transmitted disease diagnosis & treatment
___ HIV/AIDS treatment, testing & diagnosis ___ Mental illness or psychiatric treatment & diagnosis

MY RIGHTS:

I understand that I may revoke this authorization in writing. I understand I do not have to sign this authorization in order to obtain health care benefits, treatment, payment or enrollment. I understand that once the health information I have authorized to be disclosed reaches the noted recipient, that person or organization may re-disclose it, at which time it may no longer be protected under privacy law.

** IF A PATIENT HAS REACHED HIS/HER **13TH** BIRTHDAY, **ONLY THE PATIENT** MAY AUTHORIZE DISCLOSURE OF DRUG/ALCOHOL/MENTAL HEALTH/STD/CONTRACEPTION/TERMINATION TREATMENT AND DIAGNOSIS.**

SIGNATURE: _________________________________ DATE: ___________________
(Patient, guardian or authorized representative)

This authorization will expire 90 days from the date signed.

Northwest Orthopedic Surgeons 1/04dw