

AUTHORIZATION FOR RELEASE OF MEDICAL RECORD INFORMATION

I, _____, HEREBY AUTHORIZE THE RELEASE OF MY HEALTH INFORMATION AS LISTED BELOW.

Patient's name: _____ Date of Birth: _____

Address: _____

Telephone: _____

Provider or facility authorized to release information: Appalachian Orthopedic Center _____

Person or entity authorized to receive information: _____

Dates of Service: All Specific Dates of Service: _____

Description of information: Entire Record Other _____

Special Records: Include the following medical records if such information is included in your records. Checking the boxes is not a representation that such information exists. (See waiver in paragraph 5 below).

Include Drug and Alcohol Records Include Mental Health Records Include AIDS/HIV - Related Records

Include Sexual Abuse/Assault and Domestic Violence Counseling Records.

Purpose of Release of Information

1. This authorization will expire: Date: _____ Event: One year

Unless otherwise specified, this authorization will expire 1 year after the date of this request.

2. I understand that I may revoke this authorization at any time by notifying my provider or by notifying the provider or entity that is authorized to receive these records. I understand that revocation will not have any affect on actions taken prior to any revocation.

3. This authorization is voluntary.

4. I understand that if the organization authorized to receive the information is not a health plan or a health care provider, the information may no longer be protected by federal privacy regulations. I also understand that this information may be rereleased and no longer protected

5. By signing below, I certify that I understand the nature of this Release. If mental health records are being released as permitted by the Mental Health Procedures Act, I understand that I have a right, subject to 55 Pa. Code § 5100.33, to inspect the material to be released.

6. By signing below, I also do do not specifically waive the confidentiality protection afforded the medical information requested that is provided by Pennsylvania statutory law including but not limited to drug and alcohol abuse treatment records protected by the Pennsylvania Drug & Alcohol Abuse Control Act (71 P.S. § 1690.108), mental health records protected by the Mental Health Procedures Act (50 P.S. § 7111), AIDS and HIV-Related information protected by Confidentiality of HIV-Related Information Act (35 P.S. § 7607), and sexual abuse/assault and domestic violence counseling records protected by 42 Pa.C.S.A. § 5945.1 and 23 Pa.C.S.A. § 6116, respectively. This waiver is applicable only to this request and is not meant to be a general waiver.

Signature of Patient or Patient's Representative/Guardian

Date

Printed Name of Patient's Representative: _____ Relationship to the Patient _____