

AUTHORIZATION FOR RELEASE OF INFORMATION

I hereby authorize Appalachian Orthopedic Center, 1 Dunwoody Drive, Carlisle, PA 17015 to disclose the following information from my health records: _____

For the following purposes: _____ Please send this information via ___ mail or ___ fax to

Name: _____ Telephone: _____

Address: _____ Fax: _____

I hereby acknowledge that the above health information may be used or disclosed only until (enter specific date/event relating to the purposed for the use or disclosure): _____

I hereby acknowledge and understand that treatment is NOT conditioned upon my signing of this Authorization. I hereby acknowledge that I have the right to refuse to sign this Authorization, if I so choose. I understand that I have the right to revoke this Authorization at any time. Such revocation must be submitted in writing to the Privacy Officer at 1 Dunwoody Drive, Carlisle, PA 17015. This revocation will become effective immediately upon receipt, except to the extent those actions have already been taken in reliance of this Authorization. I understand that these rights and other privacy right pertaining to me are detailed in Appalachian Orthopedic Centers Notice of Practices.

I acknowledge that I have been informed and understand that information used or disclosed pursuant to this Authorization may be subject to re-disclosure and, at that point, the information may no longer be protected under the terms of this Authorization agreement.

I HAVE READ AND UNDERSTAND THIS INFORMATION. I HAVE RECEIVED A COPY OF THIS AUTHORIZATION AND AFFIRM THAT I AM THER PERSON, OR I AM AUTHORIZED TO ACT ON BEHALF OF THE PERSON, TO SIGN THIS FORM VERIFYING AUTHORIZATION FOR THE USE OR DISCLOSURE OF THE PROTECTED HEALTH INFORMATION UNDER THE ABOVE TERMS.

Date: _____

Signature: _____

Print Full Name: _____

Signature of Personal Representative: _____

Print Name: _____

If individual is unable to sign and verbal authorization is granted, two witness signatures are required.

Signature and date of Witness: _____

Signature and date of Witness: _____

