AUTHORIZATION FOR RELEASE OF INFORMATION

I, _____ (Patient Name) _____(DOB)

_____ (Address) _____ (Phone)

Here by request that

ORTHOPEDIC SURGEONS OF KOKOMO, LLC
2226 WEST ALTO ROAD
KOKOMO, INDIANA 46902
(765) 868-0313 (TELEPHONE)
(765) 454-0554 (FAX)

Release to _____ (Name)

_____ (Address)

_____, (City, State, Zip)

_____ (Telephone Number) _____ (Fax Number)

For the purpose of _____.
Any and all medical records and reports concerning my medical history, physical condition, diagnosis, treatment and/or prognosis, including x-rays and other diagnostic reports, as well as any information contained in my medical records or reports that relates to treatment and/or history of psychiatric or mental health problems, drugs, or alcohol abuse problems, dangerous communicable diseases, including Acquired Immunodeficiency Syndrome (AIDS) or tests for infection with Human Immunodeficiency Virus (HIV), and any other information relating from my treatment from _____ to _____.

This release shall apply to any or all data listed above unless otherwise indicated by the patient as follows:

_____

_____.

I understand this consent can be revoked at any time except to the extent that disclosure made in good faith has already occurred in reliance on this consent.
This Authorization is valid for sixty (60) days after the date this request to release information is made, unless a different date, event or condition that would cause this Authorization to expire sooner is indicated as follows: _____

I acknowledge, upon signature of Authorization, that there may be a charge for copies of my medical records pursuant to Indiana Code 16-39-9-3

Date: _____ _____

Patient Signature
or
Patient's Legal Representative