AUTHORIZATION FOR RELEASE OF INFORMATION

I, _____(Patient Name) _____(DOB)

_____ (Address) _____ (Phone)

Here by request that the following release my medical records:

_____ (Name)

_____ (Address)

_____, (City, State, Zip)

_____ (Telephone Number) _____ (Fax Number)

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

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: _____

Date: _____ _____
Patient Signature
or
Patient's Legal Representative