Name:

DOB:

Authorization for Release from OrthoCincy

Date of Treatment: _____

OrthoCincy is hereby authorized to release copies of protected health information to:

Are the records to be (check one):

_____ Mailed
Name: _____

Address: _____

_____ Faxed
Fax #: _____ Attn: _____

_____ Emailed: _____
(Any images, such as xrays, or MRIs, can be emailed with a valid email address.)

Phone #: _____

Information to be Released to OrthoCincy (please check):

_____ All Medical Records (will include test results)

_____ X-Rays/MRI Images (If the testing was done at an outside facility, please contact them for any requests.)

_____ Disability Information

_____ Other: _____

Special Exclusions:

_____ Drug Abuse or Drug-Related Conditions

_____ Psychological and Psychiatric Conditions

_____ AIDS Diagnosis and AIDS Related Conditions

_____ Alcoholism

_____ HIV Testing

_____ Sexual Preference

I understand and agree that OrthoCincy may impose a reasonable, cost based fee for copying, including the cost of supplies and labor, postage, and preparing an explanation or summary of my protected health information requested. I understand this authorization may be revoked at any time with proper notification except to the extent action has been taken prior to revocation. I acknowledge that I have read and fully understand this authorization as it applies to me and release OrthoCincy from all legal responsibility or liability that may arise from the release of this information. I understand that the information used or disclosed may be subject to re-disclosure by the recipient listed above and will no longer be protected by federal regulations. This authorization will be effective for one year from the date of authorization.

_____

Date of Authorization

Signature of Patient/Parent/Legal Guardian

_____

Witness

A photocopy or facsimile of this authorization may be used with same authority as original.

Shown ID? _____ Date of Pickup: _____

Records were released to the patient in the clinic: _____