

**Authorization to Release Patient Medical Information**

**Patient Information**

Patient Name (Please Print) \_\_\_\_\_

Former Name (If Any) \_\_\_\_\_ Social Security# \_\_\_\_\_

Daytime Telephone \_\_\_\_\_ Birthday \_\_\_\_\_

**Information to be Released From:**

I herby authorize (name of organization) \_\_\_\_\_ Attention: \_\_\_\_\_

To release the following medical information contained in the patient's medical record.

**Information to be Released To/From:**

<u>Name of Organization</u>	<u>Street Address</u>	<u>City/State/Zip</u>

Purpose or need for this information: \_\_\_\_\_

**Type of Information to be Released:**

1. General release

<u>Type of Record</u>	<u>Dates of Treatment</u>
_____ Medical Records/Excluding Protected Records (This will be limited to 2 years of information)	From _____ To _____
_____ X-Ray results (part of medical records)	From _____ To _____
_____ X-Ray Films/MRI Films (\$5.00 per sheet)	From _____ To _____
_____ X-Ray CD/MRI CD (No Charge)	From _____ To _____
_____ Other Records (specify) _____	From _____ To _____

2. Information Protected by State/Federal Law

_____ Drug Abuse Diagnosis/Treatment	From _____ To _____
_____ Alcoholism Diagnosis/Treatment	From _____ To _____
_____ Mental Health Diagnosis/Treatment (May include treatment of pain management)	From _____ To _____
_____ Sexually Transmitted Disease Diagnosis/Treatment or Counseling	From _____ To _____

**Patient Authorization to Release Medical Information**

<u>Date</u>	<u>Signature of patient or legally responsible party</u>	<u>Relationship to patient if not patient</u>

This authorization is valid 90 days only and may be revoked in writing at any time prior to 90 days by notifying Southwest Bone and Joint Institute. (To be valid authorization must be signed and dated)