AUTHORIZATION TO RELEASE MEDICAL RECORDS

1. **I hereby authorize Orthopaedic & Sports Medicine Center, Inc. (OSMC) to release my medical information to the following individual(s):**

- ☐ Self
- ☐ Spouse: ____
- ☐ Parent(s): ______________________________________
- ☐ Employer: ______________________________________
- ☐ School: ____
- ☐ Other: ____

2. **Specific information to be disclosed (check all that apply):**

- ☐ Records of treatment including office notes and health history
- ☐ Diagnostic testing
- ☐ Digital X-ray films
- ☐ Billing Statements
- ☐ Other: ____

3. **I am requesting this information to be released for the following purpose(s):**

- ☐ Continued Care
- ☐ Insurance Claim
- ☐ Personal Use
- ☐ Other (Describe): ____

4. **I authorize all information which may be contained in my medical records at OSMC to be released unless otherwise specified here: ____**

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5. **This authorization will automatically expire on: ____/____/____ (If no expiration date is listed this authorization will expire one year from the date of my signature.)**

I give permission for this information to be released via telephone, mail, facsimile, and/or e-mail. I understand that when the information is used or disclosed pursuant to this authorization, it may be subject to re-disclosure by the recipient and may no longer be protected health information. I further understand that I have the right to revoke this authorization at any time. I understand that if I revoke this authorization, I must do so in writing and present my written revocation to OSMC. I understand that the revocation will not apply to information that has already been released in response to this authorization. I also understand that the revocation will not apply to medical information that is released for purposes of treatment, payment, and healthcare operations as outlined in OSMC's privacy notice.

___________________________________ ___________________________
Patient Name (Print) Date of Birth

___________________________________ ___________________________
Signature of Patient or Agent If Agent, relationship to patient

____
Date