

PATIENT AUTHORIZATION TO RELEASE MEDICAL INFORMATION

Patient Name: _____ Date of Birth: _____

By signing this form, I authorize you to release confidential health information about me by releasing a copy of my medical records, a summary, or a narrative of my protected health information to the physician(s) or facility listed below.

Please identify the information to be released:

_____ Release entire record -OR- Please Specify: _____

FROM: (Name and address) _____

TO: (Name and address) _____

The identified information will be used for the following purposes:

_____ Continuing care/treatment -OR- _____ Other (please describe): _____

- I understand the information in my health record may include information relating to sexually transmitted diseases, acquired immunodeficiency syndrome (AIDS), or human immunodeficiency virus (HIV). It may also include information about behavioral or mental health services and treatment for alcohol and drug abuse.
- I understand that once the information below is released, it may be re-disclosed by the recipient, and federal privacy laws or regulations may not protect the information.
- I understand 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 the practice.

The identified information may be used by or released to Integrity Orthopedics & Sports Medicine.

Patient Signature: _____ **Date:** _____

Signature of person completing this (form if not patient): _____

Relationship: _____ **Date:** _____

Witness (Practice employee): _____ **Date:** _____