ORTHOPAEDIC SPECIALISTS OF FREDERICK

AUTHORIZATION FOR RELEASE OF MEDICAL INFORMATION

(Print patients full name) _____ Birth date (Mo/Day/Yr) _____

(Street address) _____ Social security number _____

(City, state, zip code) _____ Phone (Home) _____

At the request of the individual, I _____ (patients name), do hereby authorize _____ (name of facility) to release:

_____DISCHARGE SUMMARY
_____HISTORY & PHYSICAL
_____PROGRESS NOTES
_____OPERATIVE NOTES
_____PATHOLOGY REPORTS
_____LABORATORY REPORTS
_____RADIOLOGY REPORTS
_____ECG/EEG/CARDIC CATH
_____EMERGENCY REPORTS
_____OTHER_____

_____ I do ____ I do NOT authorize release of information related to AIDS (Acquired Immunodeficiency Syndrome) or HIV (Human Immunodeficiency Virus) Infection, psychiatric care and/or psychological assessment, and treatment for alcohol and/or drug abuse.

INFORMATION RELEASE TO: _____
Name of Company/Agency/Facility/Person

_____
Street address

_____
City, state, zip

PURPOSE OF DISCLOSURE:

_____REFERRAL TO SPECIALIST _____INSURANCE _____WORKERS COMP _____CHANGE OF DOCTOR
_____LEGAL INVESTIGATION _____DISABILITY DETERMINATION _____PERSONAL _____CONTINUING CARE
OTHER (SPECIFY)_____

Please provide current telephone number in the event we need to contact you: _____

I hereby authorize disclosure of the health information for the above named patient. This authorization is valid for 12 months from the date of signature. I understand that I may cancel this request with written notification but that it will not effect any information released prior to notification of cancellation. I understand that the information used or disclosed may be subject to re-disclosure by the person or class of persons or facility receiving it, and would then no longer be protected by federal regulations. I understand that the medical provider to whom this is authorized is furnished may not condition its treatment of me on whether or not I sign the authorization.

_____ _____
Signature of individual or guardian or Personal Representative of patient's estate **Date**

NOTE: MD STATE LAWS PERMIT A FEE TO BE CHARGED FOR THE COPYING OF PATIENT RECORDS . THIS FACILITY HAS CONTRACTED WITH THE SMART CORPORATION TO MAKE COPIES. THE COPIES WILL BE MAILED ALONG WITH AN INVOICE (IF THE FEE IS APPLICABLE).

MEDICAL INFORMATION RELEASED BY SMART CORPORATION

ENTIRE_____ LAB_____ EKG_____
DS_____ EKG_____ IMMUNE_____
OP_____ X-Ray_____ OTHER_____
HP_____ PATH_____ _____

_____
ROI SPECIALIST

_____
DATE NUMBER OF PAGES