CONSULTING ORTHOPAEDICS ASSOCIATES
A DIVISION OF
THE ORTHOPAEDIC NETWORK, INC

AUTHORIZATION TO DISCLOSE HEALTH INFORMATION

Patient Name: _____________________________________ Social Security Number: ___________________
Date of Birth: ____

Physician/Organization to DISCLOSE information:
____

Person/Physician/organization to RECEIVE the information (including address)
____
____
____

Date(s) of service/care for information requested __________________________

Information to be disclosed (include dates where appropriate)
____Problem List _____________________ ____Immunization Record ______________________________
____Progress Notes ___________________ ____Laboratory Reports _______________________________
____Entire Record ____________________ ____X-rays/EKGs______________________________________
____Other____

Purpose of this disclosure
______ Continuation of medical care ______ Attorney
______ Substantiation of payment claims ______ Personal use
______ Other (specify) ____

Information should be delivered via (select one)
______ I will inspect and review the record on site ______ Mail to address above
______ Fax to: ______________________________
______ Pick-up (provide name of individual picking up information) __________________________________

1. I understand that the information in my health record may include information relating to sexually transmitted disease, tuberculosis (TB) hepatitis B, acquired immunodeficiency syndrome (AIDS), or human immunodeficiency virus (HIV). It may include information about behavioral or mental health services and treatment for alcohol and drug abuse.

2. I understand that I have a 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 Medical Record Department of the entity authorized to release this information. I understand that the revocation will not apply to information that has already been released in response to this authorization. I understand that revocation will not apply to my insurance company as the law provides my insurer with the right to contest a claim under my policy.

3. In accordance with State Law, unless otherwise revoked, for Ohio entities this authorization will expire in 60 days; for Michigan entities this authorization will expire in 6 months.

We follow the Ohio Bill #508 standard charges for copy services.

Signature of Patient of Legally Authorized Representative: ____
Date: _____________________________
If you are the legally authorized representative of the patient, describe the scope of your authority (attach necessary proof)
______ Parent ______ Durable Power of Attorney for Health Care
______ Legally Authorized Representative ______ Personal Representative of the Estate
______ Other (specify and attach proof) ____