

Central Indiana Orthopedics

AUTHORIZATION TO RELEASE INFORMATION

I hereby authorize Central Indiana Orthopedics, P.C. to release to:

Name: _____

Address: _____

Medical information from the health record of:

Patient Name: _____ **Date of Birth:** _____

Address: _____ **Telephone:** _____

Covering the treatment periods:

From (Date) _____ **to (Date)** _____

Information to be disclosed:

- Office Notes
- Laboratory Test Results
- Operative Notes
- X-Ray Reports
- X-Rays Films (Must be returned within 30 Days)
- Other _____

Specific information to be disclosed: _____

I understand that this will include information relating to (check if applicable):

- Acquired Immunodeficiency Syndrome (AIDS) or infection with HIV (Human Immunodeficiency Virus)
- Treatment for alcohol and/or drug abuse

Treating Physician: _____

Purpose of disclosure of medical information: _____

This authorization does does not include release of a copy of the itemized bill for treatment.

Billing information to be released to: _____

I understand that this authorization will remain in force for a reasonable time in order to act upon the purposes for which it is given. I also understand that I have a right to withdraw this authorization at any time. I understand that if I withdraw this authorization I must do so in writing and present my written withdrawal to the Supervisor of Medical Records. In addition, it is my understanding that if I withdraw this authorization it will not apply to any action that has been taken in reliance on it. This authorization will automatically expire sixty-days after the "Date of Signature" or on the following earlier date, as specified by me. I understand that the withdrawal will not apply to my insurance company when the law provides my insurer with the right to contest a claim under my policy.

I also understand that authorizing the disclosure of health information is voluntary. I can refuse to sign this authorization. I need not sign this form in order to assure treatment. I understand that I may inspect or copy the information to be used or disclosed, as provided by federal regulation.

I understand that any disclosure of information carries with it the potential for an unauthorized re-disclosure and the information may not be protected by federal confidentiality rules. If I have questions about disclosure of my health information, I can contact the Medical Records Dept. for more information.

This authorization will be valid for 60 days from signature, or until _____.

Patient's Signature

Guardian Signature

Date of Signature

Relationship

Witness Signature and Date

Released By: