Orthopaedic Specialists

www.oaaortho.com

RELEASE
MEDICAL INFORMATION
(PLEASE BE ADVISED THAT ALL RECORDS REQUESTS WILL TAKE APPROXIMATELY 5 BUSINESS DAYS)

Patient Name: _____
Address: _____
_____
Birthdate: _____

I hereby authorize the above entity to release information from my medical record to:

☐ Patient ☐ Doctor/Medical Provider ☐ Insurance Co ☐ Other _____

_____

(Name of Doctor, Hospital, Insurance Company or Other Agency or Person to Whom the Information will be Released

_____ Telephone Number: _____ Fax Number: _____

(Address of Receiving Party)

For the purpose of: ☐ Continuation of Medical Treatment ☐ Payment of Bill ☐ Worker's Compensation ☐ Education ☐ Legal Purposes ☐ Insurance Purposes ☐ At the Request of the Patient or the Patient's Legal Representative for personal access or other (specify): _____

Information to be released is for the time period from _____ to _____

SPECIFIC INFORMATION TO BE RELEASED:

☐ EMG Reports ☐ Laboratory Reports ☐ MRI Report ☐ Operative Reports ☐ X-Ray Reports
☐ Itemized Bill ☐ MRI Copies ☐ OAA Office Notes ☐ X-Ray Copies

☐ Other (specify): _____

I understand that this authorization is revocable by me, in writing, at any time, except to the extent that action has been taken in reliance on it. I will contact the above entity(s) immediately if I wish to revoke this authorization. As described in the Notice of Privacy Practices for the above entity(s), I may request such Notice of Privacy Practices for my ease of reference. I also understand **that this consent will expire one year after the date of signature**. I understand that the information released may be re-released by the recipient and may no longer be protected by HIPAA (Federal regulations).

Copy of Records to be Picked Up by Patient Will Only be Available for 90 Days

AUTHORIZATION SIGNATURES

NOTE: IF PATIENT IS A MINOR THE PARENT/GUARDIAN MUST SIGN (*Excluding exceptions permitted by PA & Federal Law)*

Date: _____ **Patient Signature:** _____
Patient Name (Printed): _____

If patient is unable to sign authorization form because of physical condition or age, complete the following:

Patient is a minor or patient is unable to sign authorization because _____

Date: _____ Signature: _____ Relationship: _____
(Parent/Legal or Personal Representative)

Print/Type Name: _____

Return to: **OAA Orthopaedic Specialists • 250 Cetronia Road • Attn: Medical Records • Allentown, PA 18104 • Fax: 866.644.0894**

[**INTERNAL USE ONLY** _____]