AUTHORIZATION FOR RELEASE OF INFORMATION

Please complete this form in its entirety. Items not checked or blanks unfilled are assumed to be non-applicable or specifically not authorized for release. This release is not valid if it does not contain the patient's original signature and date signed or if it has expired as described below. A copy of this signed form will be provided to the patient.

SECTION A: MUST BE COMPLETED FOR ALL AUTHORIZATIONS
I hereby authorize the use or disclosure of my individually identifiable health information as described below. I understand that this authorization is voluntary. I understand that if the organization authorized to receive the information is not a health plan or health care provider, the released information may no longer be protected by federal privacy regulations.

PATIENT NAME: ______________________________BIRTHDATE: __________TELEPHONE#: ______________________
ADDRESS:
____

FROM: **THE BONE & JOINT GROUP**
An Association of Physicians

TO: ____

____

____

Fax#: ____________________________________

Covering the periods of healthcare (date(s) of service):

From: ______________________________ To: ______________________________

ALL RECORDS WITHIN THE ABOVE TIMEFRAME WILL BE SENT UNLESS OTHERWISE SPECIFIED HERE:

____

SECTION B: MUST BE COMPLETED FOR ALL AUTHORIZATIONS

The patient or patient's representative must read and initial the following statements:

1. I understand that this authorization will expire (1) one year from today's date. ______ Initials

2. I understand that I may revoke this authorization at any time by notifying the providing organization in writing, but if I do it won't have any affect on any actions they took before they received the revocation. ______ Initials

____ ____
Signature of patient or representative Date

Printed name of representative: ____
Relationship to patient: ____