GAREY ORTHOPEDICS

Garey Orthopedic Medical Group
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AUTHORIZATION FOR USE AND DISCLOSURE OF MEDICAL INFORMATION

AUTHORIZATION

I hereby authorize _____

(Physician/Healthcare Facility)

To release information regarding _____

(Patient's name/DOB)

I, the undersigned, authorize the release of, or request access to the information specified below from the medical record(s) of the above-named patient.

PATIENT INFORMATION IS NEEDED FOR:

- ☐ Continuing Medical Care
- ☐ Insurance
- ☐ Legal Purposes
- ☐ Military/School
- ☐ Personal Use
- ☐ Social Security/Disability
- ☐ Other: _____

INFORMATION TO BE RELEASED OR ACCESSED:

- ☐ Office visits
- ☐ Operative Reports/Hospital records
- ☐ Lab/Path Reports
- ☐ X-ray CD (x-rays done in our office)
- ☐ Imaging Reports (done outside our office)
- ☐ Physical Therapy

First CD of x-rays is free of charge. Any additional CD requested, there is a $25 fee

The above information may be released (specify name or title of the individual or the name of the organization to which records are to be released and the appropriate address:

TO:

_____ _____

(Self, Doctor, Hospital, Attorney, Insurance Company, etc.) Phone Number

_____

Address

_____ _____ _____

City State Zip Code

How would you like to receive your medical records?

- ☐ Pick Up in our office.
- ☐ Mail to the address listed above.
- ☐ Emai (Records only, no x-rays): _____

DURATION:

This authorization will expire six (6) months from the date of my signature unless I revoke the authorization prior to that time.

RESTRICTIONS:

Permissions for further use or disclosure of this medical information is not granted unless another authorization is obtained from me or unless such disclosure is specifically required or permitted by law. I understand that the specified information to be released may include but it not limited to history, diagnosis and/or treatment of drug or alcohol abuse, mental illness, or communicable disease, including HIV and AIDS. A photocopy or facsimile of this authorization shall be considered as effective and valid as the original. I have been advised of my right to receive a copy of this authorization.

_____ _____

Signature of patient or legal/personal **Relationship if other than patient or legal/personal**

_____ _____

Patient's name (PRINT) **Date**