MRN:_______________

AUTHORIZATION FOR RELEASE OF MEDICAL INFORMATION

(from outside facility)

I hereby authorize the use of 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. I understand that this authorization is voluntary and I may refuse to sign it. If I choose not to sign this authorization, I understand that any and all of my medical records will not be transferable to anyone including myself.

Patient Full Name:____________________________________ DOB:_________________

Person/Organization receiving the information:

Orthopaedic Institute of Western Kentucky
200 Clint Hill Blvd
Paducah, Ky 42001
Phone 270-442-9461
Fax 270-450-7235

Person/Organization to provide the information

____

____

Fax #_______________________________

Specific description of information to be released, including dates:

*office notes, reports, and documents
*medical imaging reports and/or operative reports
*medical imaging films including xrays, CTs, and MRI's
*other

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 effect on any actions that took place before receipt of the revocation.

____
Signature of the patient or patients representative

____
Date signed

____
Printed name of patients representation

____
Relationship of representation

____
Date records were requested