THE ORTHOPAEDIC INSTITUTE

MRN:_____

AUTHORIZATION FOR RELEASE OF MEDICAL INFORMATION

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 providing 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 receive the information

_____

_____

Fax #_____

Specific description of information to be released, including dates: _____

_____

_____

_____

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