

THE PORRETTA CENTER FOR ORTHOPAEDIC SURGERY, P.C.

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Authorization for Release of Protected Health Information

Patient Name _____ Date of Birth _____
Address _____ Telephone _____
_____ Social Security # _____

INFORMATION REQUESTED:

- Records for date(s) of service _____
 Complete medical records
 X-ray films (on CD) Fee _____ Paid _____ Cash Check Charge

I would like copies of my records indicated in the section above sent:

FROM: _____ TO: _____

I authorize the release of health information contained in my medical records to the above-named parties. I understand that there may be a reasonable fee to cover obtaining and/or copying of the medical record, or any part of the medical record and that the fee must be paid in full prior to my obtaining such copies. I understand that this authorization may be revoked by me (the patient or representative) at any time, except after the release described above has taken place.

PURPOSE OF DISCLOSURE:

- Attorney/Legal Continued Patient Care Insurance Personal Use
 Worker's Compensation Other _____

It is further understood that the information released is for the specific purpose stated above and may not be provided in whole or in part to any agency, organization, or person.

Signature of Patient or Legal Representative

Date

Relationship to Patient