# Authorization for Release of Information

PATIENT NAME: _____
LAST FIRST MI

DATE OF BIRTH: _____-_____-_____ SS#: _____-_____-_____ CHART #: _____

ADDRESS: _____ CITY: _____ STATE: _____ ZIP: _____

WORK or HOME PHONE: _____ CELL PHONE: _____

**I hereby authorize Capital Area Orthopedic Associates to release information from my medical record as indicated below to the following individual:**

NAME: _____ RELATIONSHIP TO PATIENT: _____

ADDRESS: _____ CITY: _____ STATE: _____ ZIP: _____

WORK PHONE: _____ CELL PHONE: _____ FAX: _____

**INFORMATION TO BE RELEASED:**

- ☐ Visit Notes (Medical History/ Exam)
- ☐ Medications
- ☐ X-ray, MRI, CT Reports
- ☐ Physical Therapy reports
- ☐ Lab Reports
- ☐ Financial Information
- ☐ Other: _____

**PURPOSE OF DISCLOSURE:**

- ☐ Changing Physician
- ☐ Consultation/Second Opinion
- ☐ Legal
- ☐ School
- ☐ Insurance
- ☐ Worker's Compensation
- ☐ Other:_____

1. I understand that this authorization will expire ninety (90) days after I have signed the form.
2. I understand that I may revoke this authorization at any time by notifying CAOA in writing.
3. I understand that information used or disclosed pursuant to this authorization may be subject to redisclosure by the recipient and no longer be protected by Federal privacy regulations.
4. I understand that a fee of $25 will be charged for a copy of my Medical Records and $15 for a copy of my itemized bill. There is no charge for medical records if copies are sent to facilities for ongoing care or follow up treatment.
5. I authorize transmission of this information by fax.

_____ _____
SIGNATURE OF PATIENT or GUARDIAN or POWER OF ATTORNEY DATE