Orthopaedic Specialists

www.oaaortho.com
www.facebook.com/oaaortho

RELEASE MEDICAL INFORMATION

FROM:

Patient Name: _____
Address: _____
Birthdate: _____
ID#: _____
OAA MR #: _____

I hereby authorize the above entity to release information from my medical record to:

OAA ORTHOPAEDIC SPECIALISTS

(Name of Doctor, Hospital, Insurance Company or Other Agency or Person to Whom the Information will be Released)

250 CETRONIA RD, ALLENTOWN, PA 18104 Telephone Number: **610.973.6200** Fax Number: **866.644.0894**

(Address of Receiving Party)

For the purpose of: ☒**Continuation of Medical Treatment** ☐ Payment of Bill ☐ Worker's Compensation
☐ Education ☐ Legal Purposes ☐ Insurance Purposes ☐ At the Request of the Patient or the Patient's Legal Representative for personal access or other (specify): _____

Information to be released is for the time period from _____ to _____

SPECIFIC INFORMATION TO BE RELEASED:

☐ Discharge Summary	☐ OAA Office Notes	☐ Emergency Room Notes	☐ Itemized Bill
☐ Pathology Reports	☐ X-Ray Reports	☐ Operative Reports	☐ History & Physical
☐ Consultation Report(s)	☐ Laboratory Reports	☐ Rheumatology Office Notes	☐ PT Office Notes
☐ MRI Reports	☐ MRI Copies	☐ EMG Reports	☐ X-Ray Copies
☐ OT Office Notes	☐ Other (specify): _____		

I understand that this authorization is revocable by me, in writing, at any time, except to the extent that action has been taken in reliance on it. I will contact the above entity(s) immediately if I wish to revoke this authorization. As described in the Notice of Privacy Practices for the above entity(s), I may request such Notice of Privacy Practices for my ease of reference. I also understand **that this consent will expire one year after the date of signature**. I understand that the information released may be re-released by the recipient and may no longer be protected by HIPAA (Federal regulations).

Copy of Records to be Picked Up by Patient Will Only be Available for 90 Days

SPECIAL AUTHORIZATION (if applicable)

If you ***DO NOT WISH*** the above entity(s) to release information related to the testing, diagnosis and/or treatment for any of the following conditions, please sign your initials in front of the section which describes the type of information ***NOT TO BE RELEASED***.

_____ My evaluation, testing, diagnosis or treatment for alcoholism and/or drug abuse or dependence **may not** be released to the recipient noted on the signed authorization.

_____ My evaluation, testing, diagnosis or treatment concerning my mental health/rehabilitation and/or neuro-psychological information **may not** be released to the recipient noted on the signed authorization.

_____ My testing, diagnosis or treatment for HIV/AIDS **may not** be released to the recipient noted on this signed authorization.

AUTHORIZATION SIGNATURES

NOTE: IF PATIENT IS A MINOR, THE PARENT/GUARDIAN MUST SIGN (*Excluding exceptions permitted by PA & Federal Law)*

Date: _____ **Patient Signature:** _____
Patient Name (Printed): _____

If patient is unable to sign authorization form because of physical condition or age, complete the following:

Patient is a minor or patient is unable to sign authorization because _____

Date: _____ **Signature:** _____ **Relationship:** _____
(Parent/Legal or Personal Representative)

Print Name: _____