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RELEASE
MEDICAL INFORMATION
(PLEASE BE ADVISED THAT ALL RECORDS REQUESTS
WILL TAKE APPROXIMATELY 5 BUSINESS DAYS)

Patient Name:
Address:
Address:
Date of Birth:
OAA MR #:

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

Patient Doctor/Medical Provider Insurance Co Other

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

Telephone Number: Fax Number:

(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/Type Name: