AUTHORIZATION FOR RELEASE OF MEDICAL RECORDS

** PLEASE COMPLETE ALL SECTIONS OF THE FORM FOR THE RELEASE OF YOUR MEDICAL RECORDS. IF YOU HAVE ANY QUESTIONS PLEASE ASK THE FRONT DESK.

Name of Patient ______________________ Soc. Security# ______________________

Address: ______________________ Phone Number ______________________

______________________ Date of Birth: ______________________

Include Date Range to be Released (include date range of discharge, service, etc.) __________

Description of records to be released (Check ALL that apply)

_____Entire Medical Record _____Pathology Reports _____EKG/EEG ____History and Physical

_____Billing Records _____Labs _____Progress Notes _____Operative Reports

_____Consultation Notes _____X-Rays _____Other (Specify) ______________________

If Applicable, Please Check Specific Confidential Information for this Release Listed Below:
By signing my initials next to the specific category of highly confidential information, I am authorizing **The Orthopaedic Center, P.A.** to release the indicated type of information next to my initials pursuant to this Authorization from the treatment Dates listed above.

____HIV/AIDS Related Information ____Drug and Alcohol Information ____Genetic Information

____Mental Health & Psychotherapy Information ____Sexually Transmitted Disease Information

____Tuberculosis

The Recipient of the Medical Record Information: (An Invoice/Bill will be sent for each recipient request.)

_____Myself (the patient or guardian) **_____Other**

Name: ____________________________ Name: ________________________

Address: ___________________________ Address: ________________________

____________________________ ____________________________

Responsible Entity to be billed for Medical Record Information: (AN INVOICE/BILL WILL BE SENT FOR EACH RECIPIENT REQUEST)

______Myself (the patient or guardian) _______Other

Name: * __________________________ Name: ____________________

Address: __________________________ Address: ____________________

IF THIS IS A PATIENT REQUEST: THE PATIENT WILL BE CHARGED FOR THE MEDICAL RECORDS UNLESS OTHERWISE NOTED* **FEE: $.73 PER PAGE AND FULFILLMENT FEE (Actual Postage).**

I understand that the medical provider to whom this authorization is furnished may not condition its treatment of me on whether or not I sign the authorization. I understand that I am not required to sign this authorization and that this consent may be revoked in writing at any time. With the exception to the extent that disclosure of Protected Health Information has already occurred prior to the receipt of revocation by the named provider. To initiate revocation of this authorization a direct written correspondence must be sent to the health care provider above. Within 30 days from the request.

I certify that I have read, signed and received a copy of this authorization upon my request

______________________ ______________ ____________________________

Signature **Date** **Relationship to patient**

The Orthopaedic Center, P.A.
9420 Key West Avenue, Suite 300
Rockville, MD 20850

Attention: Medical Records
Phone: 301-251-1433 ext. 302
Fax: 301-251-2768