

CONSENT FOR RELEASE OF INFORMATION

Before Orthopedic Surgery Specialists, PLLC can complete your request for the release of protected health information to another individual, we must first verify your identity, the information you would like disclosed, to whom you authorize receiving this information, and the purpose for the request.

Please complete the information below. Be as accurate and specific as possible.

Date: _____ Time: _____

Person Requesting Release of Information:

Name: _____
Address: _____ Home Tel: _____
_____ Work Tel: _____
_____

Relationship to Person Authorizing Release of Information:

☐Spouse ☐Parent ☐ Child ☐Grandparent ☐Grandchild
☐Self ☐Legal Representative/Guardian ☐Aunt/Uncle
☐Other: _____

Name and Phone Number of Authorized Person:

1) _____ Phone:_____

2) _____ Phone: _____

3) _____ Phone: _____

Information Authorizing Release of :

☐ Lab/Test Results
☐ Billing Information
☐ Continuation of Care Issues
☐ Any Medical/Condition Information
☐ Other: (Please be specific)

☐ Prescription Information/Call-In Refills
☐ Insurance Information
☐ Emergency Contact
☐ Emergency Contact Only

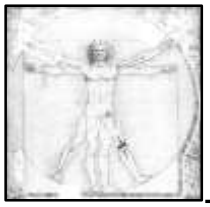
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_____

(Note: The "minimum necessary" rules may apply, and I may not receive all the requested information)

Release of Information 6/7/2013



The Purpose for Allowing the Release of My Protected Health Information:

☐ I cannot care for myself independently.
☐ I am hard of hearing and cannot communicate well on the phone.
☐ I do not speak English.
☐ I have periodic episodes of confusion.
☐ I desire the authorized person(s) named above to have the ability to communicate with my physician and his/her staff in the event I have an exacerbation of my disease process and cannot do this effectively myself.
☐ I want a copy of my records for my own personal use.
☐ Other: (Please indicate specific reason_____

_____

_____

I certify that the information on this request for release of information is true and accurate to the best of my knowledge. My signature below indicates I have willingly authorized the disclosure of the indicated information to the documented individual contained within this document. I verify and take responsibility that the disclosure(s) released by Orthopedic Surgery Specialists, PLLC will not be used for any purpose other than that listed on this form. I understand and acknowledge that Orthopedic Surgery Specialists, PLLC will not be held liable for any accidental disclosures made by individuals I have authorized to obtain my private health information. I further understand that I am bound by the terms of this form until such time I amend this consent in writing.

_____

Name of Person Requesting Release Release

Signature of Person Requesting

_____

Name of Witness

Signature of Witness

For Office Use Only

Identity of Requester Verified By: [ ] Driver's License [ ] Work/Gov't ID
[ ] Other:_____

Name of Person Verifying Requester Identity: _____

Date:_____