

COMMONWEALTH ORTHOPAEDIC ASSOCIATES

11 Fairlane Road Reading, PA 19606

AUTHORIZATION FOR RELEASE OF MEDICAL INFORMATION

(Print patients full name)

Birth date (Mo/Day/Yr)

(Street address)

Social security number

(City, state, zip code)

Phone (Home)

At the request of the individual, I _____, do hereby authorize _____ to release:
(patient's name) (name of facility)

ALL RECORDS (or list specifics below)

- | | | |
|-----------------------------|------------------------------|----------------------------|
| _____
DISCHARGE SUMMARY | _____
PATHOLOGY REPORTS | _____
EMERGENCY REPORTS |
| _____
HISTORY & PHYSICAL | _____
LABORATORY REPORTS | _____
OTHER _____ |
| _____
PROGRESS NOTES | _____
RADIOLOGY REPORTS | _____ |
| _____
OPERATIVE NOTES | _____
ECG/EEG/CARDIC CATH | _____ |

I do _____ I do **NOT** authorize release of information related to AIDS (Acquired Immunodeficiency Syndrome) or HIV (Human Immunodeficiency Virus) Infection, psychiatric care and/or psychological assessment, and treatment for alcohol and/or drug abuse.

INFORMATION RELEASE TO:

Name of Company/Agency/Facility/Person

Street address

City, state, zip

PURPOSE OF DISCLOSURE:

- | | | | |
|---------------------------------|--------------------------|------------------------|-----------------------------------|
| _____
REFERRAL TO SPECIALIST | _____
CONTINUING CARE | _____
WORKERS' COMP | _____
LEGAL INVESTIGATION |
| _____
CHANGE OF DOCTOR | _____
INSURANCE | _____
PERSONAL | _____
DISABILITY DETERMINATION |
| OTHER (SPECIFY) _____ | | | |

Please provide current telephone number in the event we need to contact you: _____

I hereby authorize disclosure of the health information for the above named patient. This authorization **is valid for 1 year** from the date of signature. I understand that I may cancel this request with written notification but that it will not effect any information released prior to notification of cancellation. I understand that the information used or disclosed may be subject to re-disclosure by the person or class of persons or facility receiving it, and would then no longer be protected by federal regulations. I understand that the medical provider to whom this is authorized is furnished may not condition its treatment of me on whether or not I sign the authorization.

**Signature of patient / legal guardian or
Personal Representative of patient's estate**

Date

NOTE: THERE WILL BE A CHARGE FOR A PERSONAL COPY OF YOUR RECORDS, OR ANY RECORDS FORWARDED TO FACILITIES. SMART CORPORATION HAS BEEN CONTRACTED TO PROVIDE THIS SERVICE AND WILL INVOICE YOU DIRECTLY.

MEDICAL INFORMATION RELEASED BY SMART CORPORATION

ENTIRE _____	LAB _____	EKG _____	_____
DS _____	EKG _____	IMMUNE _____	ROI SPECIALIST _____
OP _____	X-Ray _____	OTHER _____	_____
HP _____	PATH _____	_____	DATE _____
NUMBER OF PAGES _____	_____	_____	_____