

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)	_____ XRAY FILMS (DONE AT COA)	_____ MRI FILMS (DONE AT COA)
_____ RADIOLOGY REPORTS	_____ PATHOLOGY REPORTS	_____ HISTORY & PHYSICAL
_____ LABORATORY REPORT	_____ OPERATIVE REPORTS	_____ EMERGENCY REPORTS
_____ PROGRESS NOTES	_____ DISCHARGE SUMMARIES	_____ PHYSICAL THERAPY NOTES
_____ OPERATIVE NOTES	_____ ECG/EEG/CARDIC CATH	_____ OTHER _____

_____ 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

} **MUST BE COMPLETE
OR WILL NOT BE
PROCESSED!**

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 OTHER THAN A PHYSICIAN'S OFFICE. HEALTHPORT HAS BEEN CONTRACTED TO PROVIDE THIS SERVICE AND WILL INVOICE YOU DIRECTLY.

MEDICAL INFORMATION RELEASED BY HEALTHPORT

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