MIDLANDS ORTHOPAEDICS, P. A. (MOPA)

AUTHORIZATION FOR RELEASE OF MEDICAL INFORMATION

Print Patient’s Full Name \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_Birth Date\_\_\_\_\_\_\_\_\_\_ (DD/MM/YY)

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Street Address Social Security Number

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

City, State, Zip Code Phone (Home)

At the request of the individual, I \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_, do hereby authorize MOPA to release:

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**(Patient’s Name)**

DATES OF SERVICE: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

\_\_DISCHARGE SUMMARY

\_\_HISTORY & PHYSICAL

\_\_PROGRESS NOTES

\_\_OPERATIVE NOTES

\_\_I do \_\_I do not

\_\_PATHOLOGY REPORTS \_\_EMERGENCY REPORTS

\_\_LABORATORY REPORTS \_\_OTHER \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

\_\_RADIOLOGY REPORTS

\_\_ECG/EEG/CARIAC CATH

Authorize the 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.

RELEASE RECORDS TO: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Name of Company/Agency/Facility/Person

Street Address

City, State, Zip Code

PURPOSE OF DISCLOSURE:

\_\_REFERRAL TO SPECIALIST \_\_INSURANCE \_\_WORKERS COMP \_\_CHANGE OF DOCTOR

\_\_DISABILITY DETERMINATION \_\_PERSONAL \_\_CONTINUING CARE \_\_LEGAL INVESTIGATION

OTHER (SPECIFY): \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Please provide a 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 12 months from the date of signature. I understand that I may cancel this request with written notification but that it will not affect 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 to be furnished may not condition its treatment of me on whether or not I sign the authorization.

Signature of Individual or Guardian or Date

Personal Representative of patient’s estate

Phone:

Fax:

Email address: