Mountain View Orthopaedics
mtvieworthо.com

# Authorization for release of health information

Patient Name _____ Date of Birth (MM/DD/YYYY) ____ / ____ / ____

Address _____ Telephone _____

Provider or facility authorized to release information _____

Address _____

Person or entity authorized to receive information _____

Address _____

Type of Record ☐ Inpatient ☐ Outpatient ☐ Emergency Room
☐ Physician's Office ☐ Radiology Films ☐ Other _____

Date(s) of Treatment _____

Description of information to be used or disclosed: ☐ Entire Record ☐ Other _____

Special Records: The medical records to be released will not include records of drug and alcohol abuse program treatment, mental health treatment or HIV/ AIDS related information records unless I have specifically authorized the release of such information by my initials below.

____ Include drug and alcohol records Include mental health record ____ Include HIV Records

Purpose of Release of Information ☐ Personal Use ☐ Medical Treatment/Management
☐ Legal Proceedings ☐ Employment Related ☐ Insurance Related
☐ Other _____

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1. This authorization will expire ☐ Date (MM/DD/YYYY) ____ / ____ / ____ ☐ Event _____
   Unless otherwise specified, this authorization will expire one year after the date of this request.
2. I understand that I may revoke this authorization in writing at any time. I understand that revocation will not have any affect on actions that any health care provider took before they received the revocation.
3. This authorization is voluntary. I understand that my treatment or payment for services will not be affected if I do not sign this authorization.
4. I understand that if the organization authorized to receive the information is not a health plan or a health care provider, the information may no longer be protected by federal privacy regulations.

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Signature of patient or personal representative: _____

Print Name: _____ Date (MM/DD/YYYY): ____ / ____ / ____