

Commonwealth

Orthopaedic Centers

Authorization for Release or Access of Protected Health Information

Commonwealth Orthopaedic Centers is hereby authorized to release copies of protected health information to:

Name: _____

Address: _____

I request that Commonwealth Orthopaedic Centers to permit me to access inspect and/or obtain copies of my protected health information.

Patient Name _____ Date of Birth _____

Medical Record # _____ Social Security # _____

Dates of treatment _____

Information to be released

- Medical Records X-Rays/MRI/ Test Results
 Disability Information Other _____

Special Exclusions: All information indicated above will be released except as excluded below.

- Drug Abuse or Drug-Related Conditions Alcoholism
 Psychological and Psychiatric Conditions HIV Testing
 AIDS Diagnosis and AIDS related Conditions Sexual Preference

I understand and agree that Commonwealth Orthopaedic Centers may impose a reasonable, cost-based fee for copying, including the cost of supplies and labor, postage, and preparing an explanation or summary of my protected health information, if requested.

I understand this authorization may be revoked at any time with proper notification except to the extent action has been taken prior to revocation. I acknowledge that I have read and full understand this authorization as it applies to me and release Commonwealth Orthopaedic Centers from all legal responsibility or liability that may arise from the release of this information. This authorization will be effective for one year from the date of authorization.

Date of Authorization

Signature of Patient/Parent/Legal Guardian

Witness

A Photocopy or facsimile of this authorization may be used with the same authority as the original.