ORTHOPEDIC INSTITUTE

Authorization for Release of Health Information

***All fields must be accurately and completely filled out in order for this request to be processed.**

***Patient Information**	Legal Name:	Date of Birth: / /
	Address:	City/State/Zip:
	Primary Phone:	**E-Mail:**
	Previous Name/Maiden Name:	
***Release information from:**	Facility/Person:	
	Address:	
	City/State/Zip:	
	Phone:	Fax:
***Release information to:**	Name/Facility:	
	Address:	
	City/State/Zip:	
	Phone:	Fax:
I authorize OI to discuss the below marked information with:	**First and Last Name:**	**Relationship:**

***Information to be disclosed:** **(Check all that apply)**	All records related to a specific body part *(Include side or location)*:				
	All records for specific dates of service: START DATE: / /		END DATE: / /		
	OR				
	Billing Records		Imaging Reports		Other: (specify)
	Clinic/Office Visit Notes		Operative/Procedure Notes		
	Therapy Notes		All records		

Reason for release: **(Check all that apply)**	Continuing Care		Second Opinion		Moving	
	Worker's Compensation		Insurance Claim		Personal	
	Transfer of Care		Legal		Other: (specify)	

Notifications Regarding Release

- I understand I have the right to request my medical information. Orthopedic Institute will not withhold treatment or insurance payment in any way based on whether I sign this form and/or make this request. I have the right to a copy of this form, and to inspect or obtain a copy of the health information disclosed.
- I understand that once information is released to a third party, Orthopedic Institute can no longer protect the confidentiality of that information and it may be re-disclosed/re-released. I understand that all medical information requested will be released and may include information regarding mental health conditions, addictions, sexually transmitted diseases, and/or other sensitive records.
- Records released may include information received from other organizations.
- This authorization will be **valid for 1 year** from the date of my signature, unless a date, event or condition is otherwise specified. I may revoke this authorization by sending a written request to Orthopedic Institute to the following address: PO Box 5116, Sioux Falls, SD 57117. The revocation will take effect upon receipt.

*Patient or Representative Signature	*Self/Legal Relationship	*Date

Office Use Only: Delivery Method [ ] Pick up [ ] Fax to recipient [ ] Mail to recipient [ ] Encrypted email to patient
Completed Date: _____/______/______ Completed By: ____________________