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AUTHORIZATION TO RELEASE MEDICAL INFORMATION

REFUSAL TO COMPLETE AND SIGN THIS FORM WILL PREVENT DISCLOSURE OF INFORMATION

I, _____ (DOB) _____ (SS#)_____
Name of Patient

authorize SportsMed-Wheaton Orthopaedics, Ltd. to allow _____
Name & Address of Physician / Facility / Insurance Co. / Employer / Attorney / Agency / Family

to obtain relevant medical information from my records during the period of _____ to _____
Specify Dates

This information is for the purpose of _____
Further Treatment / Obtaining Insurance Benefits / Patient's Attorney Request / Patients' Own Records / etc.

The nature of the information to be released will be:

___ SportsMed-Wheaton Orthopaedics, Ltd. Treatment Records ___ Complete Medical Records as of this date

___ X-Ray Copy ___ MRI Film ___ Other: _____

I understand that the records contain information regarding my medical condition and treatment and possibly could include material pertaining to psychiatric or psychological diagnoses/treatment, infectious/contagious disease information (including HIV/AIDS), confidential information, and/or information about drug or alcohol abuse or treatment of same.

I understand that I, as the patient, have the right to inspect and copy information being disclosed. I further understand that this Authorization is subject to revocation by the undersigned at any time, except to the extent that action has already been taken by SportsMed-Wheaton Orthopaedics, Ltd. in reliance upon this authorization. Unless otherwise stated below, this authorization shall automatically expire thirty (30) days from the date set forth below.

I hereby release SportsMed-Wheaton Orthopaedics, Ltd. and its employees, agents, officers and affiliates from any and all liability, responsibility, claims and damages which may result from the release of information as authorized by this document.

I understand that in certain circumstances a fee may be required for photocopying, postage, etc.

I understand that if I wish another person to pick up my records on my behalf, I must specifically name them below and will advise them they will be required to present photo identification, i.e., driver's license, before my records will be released to them.

Name: _____ Relationship: _____

Notice to Receiving Agency, Facility or Person:
A patient's medical record is privileged information, which is protected by State and Federal Laws. This information may not be redisclosed to other persons or organizations without a separate written authorization from the patient.

_____ _____
Signature of Patient *Date* *Signature of Witness* *Date*

_____ _____
Signature of Parent/Guardian (if patient is under 18 years *Date* *State legal relationship to patient*

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