Central Indiana Orthopedics
INVESTED IN KEEPING YOU ACTIVE

Authorization to Release Information

I hereby authorize Central Indiana Orthopedics, P.C. to release to:

Name: _____

Address: _____

Medical information from the health record of:

Patient Name: _____ Date of Birth: _____

Address: _____ Telephone: _____

Covering the treatment periods:

From (Date): _____ To (Date): _____

Information to be disclosed:

☐ Office Notes ☐ X-Ray Reports

☐ Laboratory Test Results ☐ X-Ray Films (Must be returned within 30 days)

☐ Operative Notes ☐ Other:

Specific information to be disclosed: _____

I understand that this will include information relating to (check if applicable):

☐ Acquired Immunodeficiency Syndrome (AIDS) or infection with HIV (Human Immunodeficiency Virus)

☐ Treating for alcohol and/or drug abuse

Treating Physician: _____

Purpose of disclosure of medical information: _____

This authorization ☐ does ☐ does not include release of a copy of the itemized bill for treatment.

Billing information to be released to:

I understand that this authorization will remain in force for a reasonable time in order to act upon the purposes for which it is given. I also understand that I have a right to withdraw this authorization at any time. I understand that if I withdraw this authorization, I must do so in writing and present my written withdrawal to the Supervisor of Medical Records. In addition, it is my understanding that if I withdraw this authorization, it will not apply to any action that has been taken in reliance on it. This authorization will automatically expire in sixty days after the "Date of Signature" or on the following earlier date, as specified by me. I understand that the withdrawal will not apply to my insurance company when the law provides my insurer with the right to contest a claim under my policy.

I also understand that authorizing the disclosure of health information is voluntary. I can refuse to sign this authorization. I need not sign this form in order to assure treatment. I understand that I may inspect or copy the information to be used or disclosed, as provided by federal regulation.

I understand that any disclosure of information carries with it the potential for an unauthorized re-disclosure and the information may not be protected by federal confidentiality rules. If I have questions about disclosure of my health information, I can contact the medical records department for more information.

This authorization will be valid for 60 days from signature, or until _____.

_____ _____

Patient's Signature Guardian Signature

_____ _____

Date of Signature Relationship

_____ _____

Witness Signature and Date Released By