

Authorization for Release of Health Information

I hereby authorize **Orthopedic Surgeons, Inc.** to disclose my individually identifiable health information as described below.

Records created between _____ and _____

Please **specify** what Medical Information may be released:

- | | |
|---|---|
| <input type="checkbox"/> Physician Reports | <input type="checkbox"/> Hospital Reports |
| <input type="checkbox"/> Physician Orders | <input type="checkbox"/> Activity Reports |
| <input type="checkbox"/> Radiology Reports | <input type="checkbox"/> Therapy Reports |
| <input type="checkbox"/> Laboratory Studies | <input type="checkbox"/> Nursing Notes |
| <input type="checkbox"/> Verbal Discussion Regarding Care | <input type="checkbox"/> Treatment Care Plans |

Other _____

Patient's Name _____ SSN _____ Date of Birth _____

Person authorized to receive my health information and account information

Name _____
 Address _____ City _____ State _____ Zip _____
 Relationship _____

Name _____
 Address _____ City _____ State _____ Zip _____
 Relationship _____

Name _____
 Address _____ City _____ State _____ Zip _____
 Relationship _____

Patient's Signature _____ Date _____

North Kansas City Office
located on the campus of North Kansas City Hospital
 2790 Clay Edwards Drive, Suite 650
 Kansas City, MO 64116-3278
 816-459-7500

Blue Springs Office
located on the campus of St. Mary's Medical Center
 203 NW R.D. Mize Road, Suite 250
 Blue Springs, MO 64014
 816-220-8727