OSI
ORTHOPEDICS & SPORTS MEDICINE

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RELEASE OF MEDICAL RECORDS

PATIENT'S NAME:_____

DOB:_____ **SS#:**_____

I hereby authorize medical records, created by Orthopedic Surgeons Incorporated, to be released for the above-named patient, for the Time Period: □ ***Last Week*** □ ***Last Month***

□ ***Last Year*** □ ***Past 5 Years*** □ ***Other(specific date/dates)*** _____

Date:_____
Request/Forms
Rcvd:_____

Date:_____
Recs/Forms Sent:
_____

SPECIFIC RECORDS: □ ***History & Physical*** □ ***Operative Reports***

□ ***X-Ray Report*** □ ***Consultation Report*** □ ***Office Visits***

□ ***Medical Forms Disability/FMLA*** □ ***Other*** _____

PURPOSE OF DISCLOSURE: □ ***Changing Physicians*** □ ***Continuing Care***

□ ***At my(patient's) request*** □ ***Worker's Compensation*** □ ***Second Opinion***

□ ***Legal*** □ ***Insurance*** □ ***School/Military***

□ ***Other***_____

TO BE DISCLOSED TO: **Name:** _____

Address: _____

Phone/ Fax: _____

1. I understand that this authorization will expire two years from the date signed. A photocopy of this form will be considered valid as the original.
2. I understand that I may revoke this authorization at any time by notifying OSI at the address below in writing, and this authorization will cease to be effective on the date notified except to the extent that action has already been taken reliance upon it. **Orthopedic Surgeons Inc., 2790 Clay Edwards Dr., Suite 650, North Kansas City MO 64116 Phone # 816-459-7500 Fax # 816-559-6553**
3. I understand that information used or disclosed pursuant to this authorization may be subject to re-disclosure by the recipient and no longer be protected by Federal Privacy Regulations. However, other state or federal law may prohibit the recipient from disclosing specially protected information, such as substance abuse treatment information, HIV/AIDS-related information, and psychiatric/mental health information.
4. My health care and payment for my health care will not be affected if I do not sign this form.
5. I understand that my refusal to sign this Authorization will not jeopardize my right to obtain present or future treatment for psychiatric disabilities except where disclosure of the information is necessary for treatment.
6. I understand that I will get a copy of this form after I sign it.

By signing below, I acknowledge that I have read and understand this Authorization.

SIGNATURE:_____ **DATE:**_____
(Relationship to Patient) ☐ **Self** ☐ **Parent/Legal Guardian (If Patient is a Minor/Name of Parent)**

AUTHORIZATION RECEIVED AND INSPECTED BY:_____ **Date:**_____

Revised 03/2018 tko