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Sports Medicine/Arthroscopy
Total Joint Replacement
Trauma Surgery
Foot and Ankle Surgery
Hand Surgery

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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) _____

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 _____

<p>OFFICE USE ONLY</p> <p>Date Request Received: _____</p> <p>By _____</p> <p>Fee Collected: _____</p> <p>By _____</p> <p>Records/Forms Distributed: _____</p>

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, Ste 650, North Kansas City, MO 64116
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: _____

Please fax form to 816-459-9611, email to osisecretary@osikc.com, or mail to 2790 Clay Edwards Dr. Ste 650 North Kansas City, MO 64116