The Centers
for Advanced Orthopaedics

Southern Maryland Orthopaedic & Sports
Medicine Center Division

AUTHORIZATION to RELEASE MEDICAL RECORD INFORMATION

Today's Date ________________________
Patient Name: ____
SSN: ___________________________ **DOB:** __________________________________
Address: ____
City/State/Zip Code: ____

Specific Authorization: I hereby authorize The Centers for Advanced Orthopaedics-Southern Maryland Orthopaedic & Sports Medicine Center division to release, disclose and deliver the confidential information described below to:

Authorized Recipient Information

Name: ____
Address: ____
City/State/Zip Code: ____
Telephone: ______________________________ Fax: ______________________________

For dates of treatment beginning _____/_____/_____ and ending _____/_____/_____, I authorize release of the following information (check all that applies).

[?] **Entire Record** [?] Diagnostic Studies Reports [?] Consultation Reports
[?] **Entire Record (excluding x-rays)** [?] Lab Reports [?] Emergency Room Reports
[?] Office Notes [?] Admission History & Physicals [?] X-Rays
[?] Patient Information Sheets [?] Discharge Summaries [?] Medications
[?] Operative Reports [?] Other _______________

The requested records will be used for: ____

GENERAL AUTHORIZATION: This release applies to any individually identifiable health information (Protected Health Care Information) governed and protected by the Health Insurance Portability and Accounting Act of 1996 (HIPPA), as amended and under the rules and regulations thereunder. I, the undersigned patient or legal representative hereby authorize Southern Maryland Orthopaedic & Sports Medicine Center-the Centers for Advanced Orthopaedics to use, review, give, disclose and release the health, medical and mental health information and related records for the patient named above and as specified below to the recipient named above. Method of release shall be pertinent to the need and may include photocopies,

photographs, fax copies, scanned copies, postal mail, express mail, computer files, e-mail, personal review, inspection, audio, telephone, video, electronic, or verbal communication.

AUTHORIZATION to RELEASE MEDICAL RECORD INFORMATION (continued)

OTHER TERMS AND CONDITIONS:

I understand the information in my health record may include information relating to sexually transmitted disease, acquired immunodeficiency syndrome (AIDS), or human immunodeficiency virus (HIV). It may also include information about behavioral or mental health services and treatment for alcohol and drug abuse.

It is my intent that information furnished is prohibited for any purpose other than that stated above and that the recipient is prohibited from disclosing this information to any other party to whom disclosure is not necessary or required for the purpose stated above. I further direct that only information prior to the date of my signature below be honored, that this request be transmitted to you within ninety (90) days of my signature below, and that a photocopy of this authorization be granted the same authority as the original.

I further hereby release Southern Maryland Orthopaedic & Sports Medicine Center-The Centers for Advanced Orthopaedics from all legal responsibility and/or liability which may arise from the release of such records as specified above, and hereby waive all rights I have to preserve their confidentiality.

I understand that this consent can be REVOKED in writing at any time except to the extent that disclosure has already occurred in reliance on this consent.

I further understand that this consent will expire in one (1) year from the date signed and that a fee for preparing and furnishing this information may be charged if information is not intended for continuity of patient care.

I HAVE READ AND UNDERSTAND ALL INFORMATION CONTAINED HEREIN.

____ ____________________________

Patient/Legal representative Signature Date

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