MD WEST | ONE
ORTHO • NEURO • EXCELLENCE

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AUTHORIZATION FOR RELEASE OF MEDICAL INFORMATION

Purpose of Release: □ Patient Request □ Insurance □ Social Security Benefits/Claim
□ Continued Care □ Attorney □ Other _____

I hereby authorize the above facility to release the following information from the records of:

Patient Name: **Date of Birth:**

Address:

City/State/Zip:

Daytime Telephone where you can be reached:

Information to be released ***TO***:

ORGANIZATION, DOCTOR OR NAME

STREET ADDRESS

CITY, STATE, ZIP

PHONE FAX

Information to be obtained ***FROM***:

ORGANIZATION, DOCTOR OR NAME

STREET ADDRESS

CITY, STATE, ZIP

PHONE FAX

☐ ALL DATES OF SERVICE ☐ SPECIFIC DATE RANGE: FROM_____ TO _____

☐ ALL RECORDS ☐ NEUROSURGERY ONLY RECORDS ☐ ORTHOPEDIC ONLY RECORDS

Specific information to be disclosed (**check all that apply**):

☐ Complete Record
☐ Medical Records (i.e office notes, progress notes)
☐ Radiology Reports
☐ Radiology Films (i.e. MRI, X-Ray, CT)
☐ Billing Statement
☐ Outside records
☐ Other: _____

As required by the Health Insurance Portability and Accountability Act of 1996, MD West ONE PC may not use or disclose your health information except as provided in our Notice of Privacy Practices without your authorization. Your signature on this form indicates that you are giving permission for the uses and discloseures of protected health information described herein.
I have the right to inspect or request a copy of this authorization. I understand there is no obligation to sign this authorization and that I may refuse to sign it. I have the right to revoke this authorization at any time by providing written notice to MD West ONE PC. This authorization will expire on _____ or 1 (one) year after the date signed.

Printed Name: _____

Signature of Patient: _____ Date: _____

Signature of Parent/Legal Guardian: _____ Date: _____