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:

- ☐ Physician Reports
- ☐ Physician Orders
- ☐ Radiology Reports
- ☐ Laboratory Studies
- ☐ Verbal Discussion Regarding Care
- ☐ Hospital Reports
- ☐ Activity Reports
- ☐ Therapy Reports
- ☐ Nursing Notes
- ☐ Treatment Care Plans

OTHER: _____

_____

_____

_____

Patient's Name Social Security Number Date of Birth

Persons authorized to receive my health information, and account information.

Name: _____

Address: _____

Relationship: _____

Name: _____

Address: _____

Relationship: _____

Name: _____

Address: _____

Relationship: _____

_____ _____

Patient's Signature Date Signed