



AUTHORIZATION FOR DISCLOSURE OF HEALTH RECORDS

I, the undersigned patient/guardian, hereby authorize Alliance Orthopaedics & Sports Medicine to release information from the medical records of:

Patient: _____

Birthdate: _____

SSN: _____

Purpose Of Request:

Second Opinion

Continuation Of My Treatment

For My Attorney

Transfer Of My Care To Another Provider

For Completion Of Form

Other _____

I authorize the release of the following protected health information:

_____ All Medical Records / All Protected Health Information

_____ Medical Records During The Period Of: _____ To _____

_____ Operative Report

Party To Whom Records Should Be Released:

Name _____

Address _____

Phone # _____ Fax # _____

I understand that this authorization for release of information is in force:

_____ Until revoked by me in writing or

_____ Until _____ (Date)

Signature of Patient/Guardian

Date

Printed Name Of Patient/Guardian