RELEASE OF INFORMATION CONSENT FORM

University Orthopedics Center
Not affiliated with Penn State University

101 Regent Court ♦ State College, PA 16801 ♦ Phone (814) 231-2101 ♦ Fax (814) 231-8569

Patient Name:_____ Patient Address: _____

_____

Birthdate: _____

I herby authorize: _____

To release the requested portions of my medical records to:

Name:_____

Address: _____

RELEASE PURPOSE: _____

I UNDERSTAND THAT THIS CONSENT MAY BE REVOKED BY ME, IN WRITING AT ANY TIME, EXCEPT TO THE EXTENT THAT ACTION HAS BEEN TAKEN IN RELIANCE UPON IT. I ALSO ACKNOWLEDGE THAT THE INFORMATION DISCLOSED PURSUANT TO THIS AUTHORIZATION MAY BE SUBJECT TO RE-DISCLOSURE BY THE RECIPIENT AND NO LONGER PROTECTED BY FEDERAL LAW. I UNDERSTAND THAT SIGNING THIS AUTHORIZATION IS VOLUNTARY. MY TREATMENT, PAYMENT, ENROLLMENT IN A HEALTH PLAN, OR ELIGIBILITY FOR BENEFITS WILL NOT BE CONDITIONED UPON MY AUTHORIZATION OF THIS DISCLOSURE.

Records Requested: (Check appropriate boxes)

Office Visit Note	☐	Correspondence from other Physicians	☐
Operative Report	☐	Physical Therapy Reports	☐
Lab Reports	☐	PT Treatment Plan	☐
X-ray Films/CD	☐	X-Ray Reports	☐
Other	☐ Details: _____		

DATES OF RECORDS REQUESTED: (REQUIRED) _____

This authorization shall be valid from: _____ (Today's date) for 180 days following effective date.

PATIENT SIGNATURE _____

DATE OF SIGNATURE _____

IF A PATIENT IS UNABLE TO SIGN CONSENT OR IS A MINOR, COMPLETE THE FOLLOWING:

PATIENT IS A MINOR ☐ YEARS OF AGE: _____

PATIENT IS UNABLE TO SIGN ☐ REASON: _____

Relationship: PARENT ☐ LEGAL GUARDIAN ☐ OTHER ☐

THE FOLLOWING INFORMATION IS PROTECTED BY STATE AND FEDERAL LAW. IF ANY OF THIS INFORMATION APPLIES TO YOU, PLEASE INDICATE ANY OR ALL INFORMATION YOU WOULD LIKE RELEASE.

HIV(ACT 148) ☐ Alcohol or drug abuse ☐ Psychiatric ☐