# AUTHORIZATION FOR RELEASE OF MEDICAL RECORDS

Patient Name: _____

Date of Birth _____ Date of Request _____

I hereby authorize Orthopaedic Associates of Rochester, P.C. to
( ) release information TO ( ) obtain information FROM

Name of Provider/Facility _____

Address _____ Zip _____

Telephone _____Contact Person _____

The PURPOSE of this request is (check all that apply)
□ My ongoing care □ Insurance matter □ Transferring care / moving
□ Second Opinion □ Personal □ Other _____

Please transfer:
□ Information pertaining specifically to: _____
□ Operative report □ History & Exam □ Discharge Summary
□ X-ray reports □ Test Results □ Physical Therapy
□ Entire Medical Record
□ Entire medical record related to specific injury or illness
Specify injury, illness, or date range _____

This authorization applies to the records for treatment received on or prior to the date of this authorization.
Authorization is VALID for this request only, and will be valid for one year from the date of this authorization or until _____.

*I understand that my right to healthcare treatment is not conditioned on this authorization. I may revoke this authorization at any time by submitting a written request to Orthopaedic Associates of Rochester, except where a disclosure has already been made in reliance on my prior authorization.*
*I understand that if the person or facility receiving this information is not a healthcare or medical insurance provider covered by privacy regulations, the information stated above could be redisclosed. Release of information related to HIV, mental health, substance abuse diagnoses or treatment records require additional authorization.*
*I understand there may be a charge for multiple copies of my records. I may request a copy of this authorization form at no charge.*

SIGNATURE OF PATIENT or Authorized Representative _____

Print name of Authorized Representative _____

Address/ phone of Authorized Rep _____