The Orthopedic Center
510 Idlewild Avenue Ste. 200
Easton, MD 21601

Authorization to Release Protected Health Information

Instructions: If any section is incomplete, this form my be invalid.

TOC Acct #	Patient Name (First, Middle, Last)	Birth Date (MM, DD, YYYY)

Release Information From

☐ The Orthopedic Center

☐ Other (Specify facility/ individual & address below, including phone if known)

Release Information To

☐ The Orthopedic Center

☐ Other (Specify facility/ individual & address below, including phone if known)

Purpose of Release

☐ Treatment/ Continue Care ☐ Disability Determination ☐ Personal
☐ Payment of Insurance Claim ☐ Legal Purposes ☐ Application for Insurance
☐ Other _____

Information to be Released

Service Dates (Optional) From To

☐ Billing/ insurance information
☐ Medical conditions including: _____
☐ Procedures relating to: _____
☐ My entire medical record
☐ Electronic format ($6.50 per CD) + postage

Sensitive Protected Health Information
☐ Psychotherapy notes ☐ HIV/AIDS information ☐ Other _____
☐ Mental health information ☐ Substance abuse treatment

I understand the information to be released may include records related to behavior and/or mental health care, alcohol and drug treatment, HIV/AIDS, and genetics. This authorization may be revoked at any time except that action has been taken in reliance upon it. Revocation must be in writing to the provider/ facility releasing the information. The provider/ facility will not condition treatment on whether I sign the authorization. ***I may be charged for copies/ CD in accordance with state law.*** Information used or disclosed pursuant to this authorization may be subject to redisclosure by the recipient and may no longer be protected by federal law.

Attention: This is a legal document. Please read carefully. By signing, you agree that you understand and accept the terms on this form.

→ **If the patient is 18 years of age or older**, the patient must sign and date the form.

→**If the patient is 18 years of age or older and is incapable of signing**, a legally authorized substitute (documentation required) may sign and date the form.

→**If the patient is 17 years of age or younger**, the patient's parent or legal guardian must sign and date form, unless exception exists under state or federal law.

Signature (Required) **Date Signed** (Required) (MM,DD,YYYY)

Printed Name of Person Signing (If Not Patient)