PRECISION ORTHOPAEDIC SPECIALTIES, INC.

AUTHORIZATION TO OBTAIN HEALTH INFORMATION FROM ANOTHER PROVIDER

Name:_____ **Date of Birth:** _____
Last **First** **Middle**

Authorization for Release of Information: I hereby voluntarily grant permission to the following health care provider to release my health information during the term of this Authorization to the recipient that I have identified below. **I understand that the information released may contain information concerning treatment for a psychiatric condition, a sexually transmitted disease, alcohol or drug treatment/abuse, HIV test results, an AIDS diagnosis or related condition and I expressly consent to such release.**

Health Care Provider: _____

Address: _____

_____

City/State/Zip Code: _____

Phone number: _____

Recipient: Precision Orthopaedic Specialties, Inc.
150 Seventh Avenue, Suite 200
Chardon, OH 44024
Phone: (440) 285-4999
Fax: (440) 285-4996

Purpose: The specific purpose of this Authorization is:

- ❑ Patient Care/At the request of the Patient
- ❑ Legal
- ❑ Other: _____

Information to be released:

- ❑ All of my medical records for any and all medical treatment provided by the health care provider.
- ❑ All of my health information described above except for the following:
  _____.
- ❑ All of my medical records that the health care provider has in its possession, including hospital records, medical records/correspondence of medical providers that are not part of health care provider's practice.
- ❑ Only the following records or types of health information: (Insert dates of treatment, types of treatment or other designation.)_____.
- ❑ MRI Disc(s)
- ❑ X-RAYS

Term: This Authorization will remain in effect:

- ❑ From the date of this Authorization until the _____ day of _____, 201__.
- ❑ Until medical provider fulfills this request.
- ❑ Until the following event occurs: _____.

Redisclosure: I understand that once health care provider discloses my health information to the recipient identified above, the health care provider cannot guarantee that the recipient will not redisclose my health information to a third party. The third party may not be required to abide by this Authorization or applicable federal and state law governing the use and disclosure of my health information. I hereby release health care provider and its staff from any/all legal liability that may arise from the release of this information to the recipient named above.

Revocation: I understand that this Authorization will remain in effect until the term of this Authorization expires or I provide a written notice of revocation to health care provider's Privacy Officer at the address listed above. The revocation will be effective immediately upon health care provider's receipt of my written notice, except that the revocation will not have any effect on any action taken by health care provider in reliance on this Authorization before it received my written notice of revocation.

_____	_____	_____
Signature	Date	Signature of Witness

If patient is unable to sign this Authorization, please complete the information below. If other than patient's signature, a copy of legal papers verifying authority (e.g. Power of Attorney or Death Certificate) **MUST** accompany this Authorization when presented. Exception: parent signing for patient under age 18. If patient is deceased, executor/administrator of patient's estate or nearest relative may sign.

_____	_____	_____
Name of Legal Representative	Date	Signature of Witness

_____
Legal Status/Relationship
(e.g.: Parent/Guardian/Executor)