PRECISION ORTHOPAEDIC SPECIALTIES, INC.

AUTHORIZATION FOR RELEASE OF HEALTH INFORMATION

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

Authorization for Release of Information: I voluntarily authorize and direct PRECISION ORTHOPAEDIC SPECIALTIES, INC. ("PRECISION") 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.**

Recipient: Person or entity to whom PRECISION may disclose my health information:

Name: _____

Address of the recipient: _____

City/State/Zip Code: _____

Phone number of recipient: _____

Purpose: The specific purpose of this Authorization is:

- ❑ Patient Care/At the request of the patient
- ❑ Legal
- ❑ Other

Information to be released: This Authorization permits PRECISION to release the following medical records:

- ❑ All of my medical records for any and all medical treatment provided by the physicians of PRECISION.
- ❑ All of my health information described above except for the following: _____.
- ❑ All of my medical records that PRECISION has in its possession, including hospital records, medical records/correspondence of medical providers that are not part of PRECISION'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 PRECISION fulfills this request.
- ❑ Until the following event occurs: _____.

Redisclosure: I understand that once PRECISION discloses my health information to the recipient identified above, PRECISION 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 PRECISION and its staff from any/all legal liability that may arise from the release of this information to the recipient named above.

Refusal to sign/right to revoke: I understand that I may refuse to sign or may revoke this Authorization at any time for any reason by providing my written notice of revocation to PRECISION's Privacy Officer and that such refusal or revocation will not affect the commencement, continuation or quality of my treatment by PRECISION.

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 PRECISION's Privacy Office at the address listed below. The revocation will be effective immediately upon PRECISION'S receipt of my written notice, except that the revocation will not have any effect on any action taken by my health care provider in reliance on this Authorization before it received my written notice of revocation.

Questions: I may contact the PRECISION Privacy Officer for answers to my questions about the privacy of my health information at 150 Seventh Avenue, Suite 200, Chardon, OH 44024, or by telephone at (440) 285-4999 Ext. 254.

_____	_____	_____
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)

FOR PRECISION'S STAFF ONLY:

Request processed by: _____

Date processed: _____

Transmitted by: **Mail** **Fax** **Electronically**