Orthopaedic Surgery Associates

OF MARQUETTE PC

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906-225-1321 Appointments • 906-228-9371 Fax Number • 1-800-462-6367 Wats Number • www.upbonedoctors.com

Authorization for Release of Medical Information

Last Name ____________________ First Name ____________________ M.I. ________

Maiden Name (If Applicable) ____________________ Phone Number ____________________

Address ____ Apt. No. ____________

City ____________________ State ______ Zip ____________

Date of Birth ____

Attending Physician ____

1. The information specified below is to be released to (Name, Address):

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I specifically authorize Orthopaedic Surgery Associates of Marquette, P.C. and/or its representative agent(s) to release the following medical record information, including information pertaining to: (Please place your initials on the line, when appropriate).

____ Mental Health ____ Drug and Alcohol Treatment ____ HIV/AIDS Information

Record	Date of Service	Record	Date of Service
___ X-Ray Report	____________	___ Inpatient-Hospital	____________
___ X-Ray Film(s)	____________	___ Procedure Report	____________
___ Lab Report(s) and/or Special Study Report	____________	___ Other	____________

2. I understand that this authorization expires (State date or event): ____________________
3. I understand that I may revoke this authorization (except to the extent that action was already taken in reliance on this signed authorization) at any time by notifying Orthopaedic Surgery Associates of Marquette, P.C. in writing.
4. I hereby agree to indemnify and hold Orthopaedic Surgery Associates of Marquette, P.C., their employees and agents free and harmless from any action against them for alleged invasion of privacy, libel or slander, or defamation arising from or related to disclosure of such information.
5. I understand that once my health information is used or disclosed pursuant to this authorization, it may be subject to re-disclosure or release by the Receiving Party and may no longer be protected by federal or state law, unless protected by 42 CFR Part 2 and Public Act 258 in which case it cannot be re-disclosed by the Receiving Party without my written authorization.

NOTICE OF RECEIVING PARTY OF DRUG AND ALCOHOL ABUSE INFORMATION

6. This information has been disclosed to you from records whose confidentiality is protected by Federal Law. Federal Regulations (42 CFR Part 2 and Public Act 258) prohibit from making further disclosure of it without specific written authorization of the person to whom it pertains, or as otherwise permitted by such regulations. A general authorization for the release of medical or other information is not sufficient for this purpose.

____ ____________
Patient or Patient's Legal Representative's Signature Date

____ ____________
Relationship if Other than Patient Witness

This patient is unable to provide written authorization because: ____________________

In non-emergency situations documentation of authority must be attached if anyone other than the patient signs this authorization.

☐ **Authorization Attached**