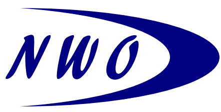

Northwest Ohio Orthopedics & Sports Medicine, Inc.

AUTHORIZATION FOR RELEASE OF MEDICAL INFORMATION/FILMS

Patient Name: ______________________________________ Date of Birth: _______________ Phone Number: _______________

Requested Pickup/Fax/Mail Date: _____________________ Patient Address: ____

Description of the information to be disclosed:

☐ Entire Medical Record ☐ Imaging Reports (Specify Type of Image): ____________________________________

☐ Progress/Office Notes ____

☐ Operative Reports ☐ Reports Only ☐ CD Only ☐ Both

☐ Laboratory/Pathology Reports ☐ Physical/Occupational/Chiropractic Notes

☐ Billing Statements ☐ Other: ____

☐ **Body Part and Date Range for Requested Information:** ____

Purpose of this request:

☐ Referral to another physician ☐ BWC Hearing ☐ Patient Request ☐ Billing Purposes

Other: ____

Name and address of person or facility to receive health information via (check one) ☐ Pick Up ☐ Fax ☐ Mail:

Name: __________________________________ Address: ____

Phone: __________________________________ Fax: ____

Staff Initials Receiving Request: ______________

Expiration of Authorization: This authorization expires _________________ (enter date or event). Unless otherwise noted, this authorization will expire 12 months after the date of the signature on this form.

My Rights: I may revoke this authorization at any time, provided I do so in writing and submit it to Northwest Ohio Orthopedics & Sports Medicine, Inc. The revocation will take effect when it is received. I also understand that revocation will not apply to information that has already been released in response to this authorization.

This authorization is voluntary. Failure to provide authorization can not be used as a condition to deny treatment unless a.) It is research related treatment. b.) Used for eligibility or enrollment in a health plan. c.) The determination of an entity's obligation to pay a claim. d.) Creating health information to provide to third party.

Notice: Northwest Ohio Orthopedics & Sports Medicine, Inc is required by law to keep your health information confidential. If you give authorization to disclose information to someone who is not legally required to keep it confidential, it may no longer be protected by state and federal confidentiality laws.

Authorization: I authorize Northwest Ohio Orthopedics & Sports Medicine, Inc. to release the health information for myself/patient listed above to the person/facility listed per the instructions outlined in this request. By signing below, I understand and acknowledge the following: 1.) I have read and understand this authorization and 2.) If I have any questions about disclosure of my protected health information, I may contact Matt Boehm, NWO Privacy Officer. I have the right to a copy of this request.

____ ______________________________________

Signature of Patient or Patient Representative Date

____ ______________________________________

Printed Name Relationship/Authorization (if other than Patient)

Staff Initials Receiving Signature: ____________

Imaging Department Use:

CDs/Films Printed: ____ ☐ Fee Applicable? Initials: ______

____

____

Medical Records Department Use:

Request Completed By: ___________________ Date: ________ ☐ Recorded in WF ☐ Invoice Amt (If Applicable): __________

7595 CR 236 · Findlay, OH 45840 · Phone (419) 427-1984 · Fax (419) 427-2864

Approved: 07.23.09