



Northwest Ohio Orthopedics & Sports Medicine, Inc.

AUTHORIZATION FOR RELEASE OF MEDICAL INFORMATION/FILMS

Date of Request: _____
Patient Name: _____ Date of Birth: _____ Phone Number: _____

Description of the information to be disclosed: Check all that apply

- Entire Medical Record**
 - Include outside physician records
- Progress/Office Notes** All
 - Dates: _____
- Operative Reports** All
 - Dates: _____
- Laboratory/Path Reports** All
 - Dates: _____
- Imaging Reports** All
 - Dates: _____
 - Reports Only CD Only Both
- Billing Statements** All
 - Dates: _____
- Physical/Occupational/Chiropractic Notes** All
 - Dates: _____
- Other** _____

Body Part and Date Range for Requested Information: _____

Name and address of person or facility to receive health information via (check one)

- Pick Up (circle one)** Findlay Office Tiffin Office Fostoria Office
- Fax** - - - - - **Attn:** _____ **Email** _____

Mail
Name: _____ Address: _____

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.
Staff Initials Receiving Request: _____

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: _____