7601 W. Jefferson Boulevard, Fort Wayne, IN 46804
Phone: (260) 436-8686 Fax: (260) 436-8585
Text: (260) 434-2602

Release of Information

Today's Date_____ **(Initials):** _____

Patient's Full Name_____ **Date of Birth** _____

Daytime Phone: _____ **Email Address** _____

Mailing Address (Street, City, State, Zip) _____

I hereby authorize records FROM:
Fort Wayne Orthopedics
7601 West Jefferson Boulevard
Fort Wayne, IN 46804
PHONE: (260) 436-8686 FAX: (260) 434-2701

To be released TO:
□ Patient (Please circle one) **Portal, fax, email or mail**
□ Other: (Please complete name and address below)

_____
_____
PHONE FAX #:

Purpose of Disclosure:

	Self/Personal Copy		*Transfer of Continuity of Care*
	Litigation		*Disability*
	Insurance		*Work Comp*
	Other		

Description of Disclosure: Please be sure to mark what types of records you are wanting released.

	Physician Office Notes		*X-ray/MRI Reports*
	Op/Procedure Reports		*Lab/Path Reports*
	Other		
	Date Range From:		To:

- I understand that the information in my medical record may include information relating to sexually transmitted disease, acquired immunodeficiency syndrome (AIDS), or human immunodeficiency virus (HIV). It may also include information about behavioral or mental health services, and treatment for alcohol and drug abuse.
- This authorization will expire one year from the date of your signature below, unless you specify an earlier termination date. You must renew or submit a new authorization after the expiration date to continue the authorization. Please list the date of expiration if earlier than one year from the date of execution of this document: _____
- You have the right to revoke or terminate this authorization at any time by submitting a written request to our Privacy Manager. Termination of this authorization will be effective upon written notice, except where a disclosure has already been made based on prior authorization.
- The practice places no condition to sign this authorization on the delivery of healthcare or treatment.
- We have no control over the person(s) you have listed to receive your protected health information. Therefore, your protected health information disclosed under this authorization may no longer be protected by the requirements of the Privacy Rule and will no longer be the responsibility of the practice.

I have read the information provided on this release form and do hereby acknowledge that I am familiar with and fully understand the terms and conditions of the authorization.

_____
Patient or Representative Signature Date

_____
Printed Name Relationship (Self" or Authorized Representatives Only*)

*Legal paperwork for authorized representatives, including biological/adoptive parents, legal guardians and medical powers of attorney, must be on file.