Independence Orthopedics & Sports Medicine
10 N Locust Street Ste.B, Oxford, Ohio 45056 · Phone: 513-523-2663 · Fax: 513-523-6968

Authorization For Release Of Protected Health Information

I authorize ____ to release my individual identifiable health information as described below. Review of records is also authorized. Information disclosed pursuant to this Authorization may be subject to redisclosure by the recipient and no longer protected under federal privacy regulations. I understand that I have the right to revoke this authorization at any time, in writing, except to the extent that action has already been taken prior to the revocation or as otherwise required by law. (Contact office to revoke.)

Patient Information:

Patient Name (Last, First, Middle Initial): ____

Patient Name at time of treatment *if different from above:* ________________________________

Date of Birth: ______________________________ Social Security # ___________________________

Telephone # ______________________________

Date(s) of service or treatment: ____

Release Information To:

Independence Orthopedics & Sports Medicine
10 N Locust Street, Ste. B, Oxford, Ohio 45056
Phone: 513-523-2663 · Fax: 513-523-6968

Purpose Or Reason For Release Of Information:

□ Continuing treatment/medical care
□ At the request of the patient
□ Insurance eligibility &/or benefits
□ Disability determination
□ Residence location
□ Legal matter
□ Other (specify): ____________________________________

Information To Be Released:

□ History and Physical
□ Discharge Summary
□ Operative Report(s)
□ Consultation(s)
□ Lab Report(s)
□ Imaging/x-ray report(s)
□ Emergency treatment
□ Pathology Report(s)
□ EKG Report(s)
□ Other (specify) ____

Signature And Date:

Authorization will expire in 60 days unless and earlier expiration is indicated here:

Patient Signature: ____________________________________ Date: ____________________________