RADFORD ORTHOPEDIC CENTER, P.C.

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MEDICAL RECORDS RELEASE

I, the undersigned do hereby authorize and request **RADFORD ORTHOPEDIC CTR, PC** to release the protected health information of: _____
Patient's Name

Address:_____ Date of Birth: _____
_____ Social Security #: _____
_____ Phone #: _____

To the Following:
Name: _____
Address: _____
_____
_____

The **Purpose** of this disclosure is for: ____Medical Care, ____Insurance Processing, ____ Legal _____Other (Specify)

I understand that:

- My treatment, payment, enrollment or eligibility for benefits will not be conditioned on signing this authorization.
- I may withdraw (revoke), in writing, this authorization by completing a "Request to Revoke Protected Health Information." Withdrawal of this authorization does not affect any protected health information disclosed prior to the receipt of written notice of revocation.
- The potential for information disclosed may be redisclosed by the recipient and no longer protected.
- This authorization will automatically expire one year after the day below **OR** on _____
  (specify date)

Signature: _____ Date: _____
(Signature of Patient / Parent / Legal Guardian / Representative)

_____
(Relationship to Patient)

NOTE: This information has been disclosed to you from records protected by Federal confidentiality rules (42 CFR Part 2). The Federal rules prohibit you from making any further disclosure of this information unless further disclosure is expressly permitted by the written consent of the person to whom it pertains or as otherwise permitted by 42 CFR part 2.