The Centers for Advanced Orthopaedics
Anne Arundel Orthopaedic Surgeons

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CONSENT FOR RELEASE OF MEDICAL INFORMATION

I hereby authorize Anne Arundel Orthopaedic Surgeons, P.A., to release my medical record information including dates, history of illness, diagnostic and therapeutic treatment. The medical records to be released may contain medical information pertaining to psychiatric, drug and/or alcohol diagnosis and treatment.

Patient Name: _____ Med Rec#: _____

Address:_____

City: _____ State: _____ Zip Code: _____

Birthdate: _____ Social Security#: _____ Phone: _____

Covering record(s) for the period from _____ to _____
Date Date

Information to be released: ( ) Copy of complete health record(s) ( ) History and Physical
( ) Abstract ( ) Discharge Summary ( ) Operative Report ( ) X-rays ( ) MRI ( ) CT

Other _____
(Note: A fee may be charged for copies of the medical records.)

Information to be released to: _____

_____

Purpose of disclosure:_____

- In addition, I authorize disclosure of medical records received from other providers. (Note: The disclosure of records furnished by other providers may be prohibited by those providers.)
- I understand this consent can be revoked in writing at any time. This revocation will not cover disclosures made previously in reliance on this consent.
- This authorization shall expire 90 days from the date noted below.
- The facility, its employees, officers and medical staff are released from legal responsibility or liability for the release of the information in accordance with this consent.

_____ _____
Signature of Patient or Representative Date

_____ _____
If representative, relationship to Patient Witness

( ) Records copied ( ) Mailed ( ) Ready for Pick-up Picked up by: _____
( ) ID checked Date: _____ Initials: _____ Rev. 091417