



**ORTHOPEDIC
PARTNERS**
Formerly Norwich Orthopedic Group
EST. 1957

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Chief Executive Officer

Medical Record Release of Information Authorization

WHO

Patient _____ DOB _____ SSN _____
(last 4 of SSN)

AKA or Maiden Name _____

Patient Address _____

City _____ State _____ Zip _____

Email _____ Phone _____

WHERE

Where you would like the records <i>FROM</i> : <i>If requesting from us, just write "Ortho Partners"</i>	Where you would like verbal / written information sent or discussed <i>Please complete all fields—larger files will need a complete mailing address</i>
<p>Doctor or Facility</p> <p>Name _____ Orthopedic Partners _____</p> <p>Address _____ 82 New Park Avenue _____</p> <p>City _____ North Franklin _____</p> <p>State _____ CT _____ Zip _____ 06254 _____</p> <p>Fax _____ 860-823-2949 _____</p>	<p>_____ Self _____ Family Member _____ Other</p> <p>Name _____</p> <p>Address _____</p> <p>City _____</p> <p>State _____ Zip _____</p> <p>Fax _____</p>

WHAT

In order to receive the fastest services, please specify the information that is requested. Larger files will take longer to process and deliver. Reducing requests to the minimum necessary allows for us to provide the fastest turnaround times.

Dates of Service _____ to _____

Incident or Injury Date _____ specific care (e.g. left knee) _____

Specific Information _____

WHY

Purpose of Disclosure—Please Select All that Apply

_____ Granting permission to speak with _____ Send records only _____ Send x-ray images only
the above person(s) / entity

You **MUST** agree or disagree to each of the following—please be advised that disagreeing to any of the following may result in portions of your medical file being withheld from the response.

Unless otherwise revoked, this authorization will expire from the date that it was originally signed:

(choose one) _____ expires in 6 months _____ expires in 1 year

My evaluation, diagnosis and / or treatment relating to the conditions listed below may be released to the requestor identified above for the following type of records unless otherwise indicated

Agree _____ Disagree _____ - AIDS (Acquired Immunodeficiency Syndrome) or HIV (Human Immunodeficiency Virus) Infection

Agree _____ Disagree _____ - Psychiatric care and / or psychological assessment

Agree _____ Disagree _____ - Treatment for alcohol and / or drug abuse

Agree _____ Disagree _____ - Mental Health Treatment

Failure to complete this section will automatically imply a declination of the above

I understand that I have the right to revoke this authorization at any time. I understand that my revocation must be in writing and addressed to the privacy office of the above named facility authorized to make this disclosure. I understand that the revocation does not apply to information already released in response to this authorization.

I understand that any disclosure of information may be subject to re-disclosure by the recipient and may no longer be protected by federal or state law. I understand that I need not sign this authorization to assure continued treatment. I understand that I may inspect and / or copy the information to be disclosed. I understand that authorizing this is voluntary. I understand that if I have questions about disclosure of my health information, I may contact the privacy officer at the facility listed above that is authorized to disclose this information and request a copy of this authorization.

I understand that there may be a fee for this service.

Requests cannot be processed without proper authorization. Minors must have a parent’s signature. Individuals requesting records on adult patients must provide the required Power of Attorney or other supporting legal documents.

Signature of Patient or Authorized Representative

Date

Fax Request to (860) 823-2949