

AUTHORIZATION TO RELEASE MEDICAL INFORMATION

Patient _____ is requesting _____
to release medical information to AO Orthopedics, Inc.

The Medical Information is to be released for the following purpose(s):

1. _____
2. _____

The following information is to be released:

- Office Notes
- Operative and Hospital Records
- History and Physical
- Test and Radiology Results
- Complete Chart (Records generated by the practice)

Conditions:

- ✓ The patient agrees to authorize the above named individual or organization to access his / her confidential healthcare information for reasons listed above only.
- ✓ AO Orthopedics, Inc. will provide the patient with a copy of the confidential healthcare information if requested (copy fees will apply).
- ✓ The patient is voluntarily signing this authorization.
- ✓ The Patient has the right to refuse to sign or revoke the authorization at any time. The revocation must be in writing.
- ✓ This authorization will be maintained as required by law as a part of the patient's medical record.
- ✓ This authorization is in effect from: ____ / ____ / ____ to ____ / ____ / ____

Signatures:

Patient or Legal Guardian: _____ Date: ____ / ____ / ____

Practice Representative: _____ Date: ____ / ____ / ____