AUTHORIZATION TO RELEASE MEDICAL INFORMATION TO

MIDLANDS ORTHOPAEDICS & NEUROSURGERY, P. A. (MON)

Print Patient's Full Name | Birth Date (Mo/Day/Year)

Street Address | Social Security Number

City, State, Zip Code | Phone (Home)

At the request of the individual, I _____, do hereby authorize_____ to release:
(Patient's Name)

DATES OF SERVICE:_____

__ DISCHARGE SUMMARY
__ ECG/EEG/CARDIAC CATH
__ EMERGENCY REPORTS
__ HISTORY & PHYSICAL
__ IMAGING
__ LABORATORY REPORTS
__ OPERATIVE NOTES
__ PATHOLOGY REPORTS
__ PROGRESS NOTES
__ RADIOLOGY REPORTS
__ OTHER_____

___ I DO ___ I DO NOT authorize the release of information related to AIDS (Acquired Immunodeficiency Syndrome) or HIV (Human Immunodeficiency Virus) Infection, psychiatric care and/or psychological assessment, and treatment for alcohol and/or drug abuse.

RECORDS FROM: _____
Name of Company/Agency/Facility/Person

Street Address: | Fax:
City, State, Zip Code:

RELEASE RECORDS TO: MIDLANDS ORTHOPAEDICS & NEUROSURGERY, P.A.
Name of Company/Agency/Facility/Person

**attn: SECOND OPINION/TAKE OVER CARE TEAM

Street Address: 1910 Blanding Street
City, State, Zip Code: Columbia, SC 29201

Phone: 803.256.4107
Fax: 803.933.6352
Email: newopinion@midorthoneuro.com

PURPOSE OF DISCLOSURE:

__ REFERRAL TO SPECIALIST
__ DISABILITY DETERMINATION
__ INSURANCE
__ PERSONAL
__ WORKERS COMP
__ CONTINUING CARE
__ CHANGE OF DOCTOR
__LEGAL INVESTIGATION

OTHER (SPECIFY): _____

Please provide a current telephone number in the event we need to contact you: _____

I hereby authorize disclosure of the health information for the above named patient. This authorization is valid for 12 months from the date of signature. I understand that I may cancel this request with written notification but that it will not affect any information released prior to notification of cancellation. I understand that the information used or disclosed may be subject to re-disclosure by the person or class of persons or facility receiving it, and would then no longer be protected by federal regulations. I understand that the medical provider to whom this is authorized to be furnished may not condition its treatment of me on whether or not I sign the authorization.

_____ _____
Signature of Individual/Guardian/Personal Representative of patient's estate | Date