# *Southwest Orthopedics, LLP.*

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## AUTHORIZATION TO RELEASE HEALTHCARE INFORMATION

Patient's Name: _____ Date of Birth: _____

Previous Name: _____ Social Security #: *(optional)* _____

I request and authorize Doctor: _____

**To release healthcare information of the patient named above to:**

**Name:** _____

**Address:** _____

**City:** _____ **State:** _____ **Zip Code:** _____

**Phone:** _____ **Fax:** _____

**This request and authorization applies to:**

☐ Healthcare information relating to the following treatment, condition, or dates: _____

☐ **Progress Notes** ☐ **Operative Reports** ☐**Other(Specify)** _____

☐ **Lab Reports** ☐ **Special Studies (EMG, MRI, etc..)**

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☐ **Other:** _____

**For the Purpose of :** ☐ Continuity Of Medical Care ☐ Legal ☐ Insurance ☐ Other Specify)_____

☐ Yes

☐ No

I understand that this authorization is valid for 90 days from the date of my signature. I understand that this authorization authorizes the release of all my medical records. I further understand that I can revoke this authorization in writing at any time prior to the expiration date. In addition, I understand that any release of this information by the recipient without my further consent is prohibited. Finally, I understand that a photocopy of this authorization may be considered valid.

Patient Signature: _____ Date Signed: _____

THIS AUTHORIZATION EXPIRES NINETY DAYS AFTER IT IS SIGNED.