

Information Release Authorization Form

PATIENT NAME: _____

This Information Release Authorization Form directs and authorizes Orthopedic and Sport Therapy Services to release the above named patient’s Protected Health Information. This authorization can be revoked at any time by notifying Orthopedic and Sport Therapy Services. The above named patient acknowledges that authorizing the disclosure of this information may make it subject to re-disclosure and no longer protected by federal privacy regulations (45 CFR 164). _____ (initials)

I, _____, authorize Orthopedic and Sport Therapy Services to release my Protected Health Information to:

NAME: _____

ADDRESS: _____

PURPOSE FOR RELEASING INFORMATION: _____

DESCRIPTION OF INFORMATION TO BE RELEASED: _____

RELEASE EXPIRATION DATE: _____

Signature

Date

Print Name