ORTHOPEDIC ASSOCIATES OF PORT HURON, P.C.

AUTHORIZATION TO RELEASE MEDICAL RECORDS

1. **I hereby authorize ORTHOPEDIC ASSOCIATES OF PORT HURON, P.C., to release my medical information to the following individual(s):**
   - ☐ Self
   - ☐ Spouse: _____
   - ☐ Parent(s): _____
   - ☐ Employer: _____
   - ☐ School: _____
   - ☐ Other: _____

2. **Specific information to be disclosed (check all that apply):**
   - ☐ Records of treatment including office notes and health history
   - ☐ Diagnostic testing
   - ☐ Digital X-ray films
   - ☐ Billing Statements
   - ☐ Other: _____

3. **I am requesting this information to be released for the following purpose(s):**
   - ☐ Continued Care
   - ☐ Insurance Claim
   - ☐ Personal Use
   - ☐ Other (Describe): _____

4. **I authorize all information which may be contained in my medical records at Orthopedic Associates of Port Huron, P.C. to be released unless otherwise specified here:** _____
   _____
   _____

5. **This authorization will automatically expire on: ____/____/____ (If no expiration date is listed this authorization will expire one year from the date of my signature.)**

I give permission for this information to be released via telephone, mail, facsimile, and/or e-mail. I understand that when the information is used or disclosed pursuant to this authorization, it may be subject to re-disclosure by the recipient and may no longer be protected health information.

I further understand that I have the right to revoke this authorization at any time. I understand that if I revoke this authorization, I must do so in writing and present my written revocation to ORTHOPEDIC ASSOCIATES OF PORT HURON, P.C. I understand that the revocation will not apply to information that has already been released in response to this authorization. I also understand that the revocation will not apply to medical information that is released for purposes of treatment, payment, and healthcare operations as outlined in OAPH's privacy notice.

_____ _____
Patient Name (Print) Date of Birth

_____ _____
Signature of Patient or Legally Authorized Representative (Agent) If Agent, Relationship to patient

_____
Date