Orthopaedic Associates of MICHIGAN

Medical Record
Release Authorization

Form must be signed and dated each year.

(please print)
Patient Name _____ Date of Birth _____

Address _____

I hereby authorize release of records FROM:

Orthopaedic Associates of Michigan

Ph 616-459-7101 Fax 616-336-5042

To be released TO:

Name _____

Address _____

City/State/Zip _____

Ph# _____ Fax# _____

Purpose of disclosure

☐Patient Request ☐Other (please specify) _____

Date Range _____ to _____

- ☐ Office Notes
- ☐ Operative Reports
- ☐ Lab Path Reports
- ☐ Independent Medical Exam (IME)
- ☐ Radiology/X-ray/MRI *Reports*
- ☐ Radiology/X-ray/MRI *Images*
- ☐ Cardiology/EKG Reports

Other (specify) _____

This authorization will expire 12 months from your last signature below, unless you specify an earlier termination. You must renew or submit a new authorization after the expiration date to continue the authorization. Please list the date of expiration if sooner than 12 months_____

You have the right to terminate this authorization at any time by submitting a written request to our Privacy Manager. Termination of this authorization will be effective upon written notice, except where a disclosure has already been made based on prior authorization.

The practice places no condition to sign this authorization on the delivery of healthcare or treatment.

We have no control over the person(s) you have listed to receive your protected health information. Therefore, your protected health information disclosed under this authorization may no longer be protected by the requirements of the Privacy Rule, and will no longer be the responsibility of the practice.

_____ _____
Patient or Legal Representative Signature Date Signed

_____ _____
Printed Name Relationship

You have the right to receive a copy of signed authorizations upon request.

Revised Jan 2020