AUTHORIZATION TO RELEASE INFORMATION

I, _____, give permission to Delaware Orthopaedic Specialists (DOS) to disclose the following information from my health records. Any information listed below that I have crossed out may not be released. I give consent for the following information to be released:

1. Complete Health Record
2. History and Physical Examinations
3. Consultation Reports
4. X-Ray Reports
5. Discharge Summary
6. Progress Notes
7. Laboratory Results
8. Photos or Other Images

I understand this may include personal information relating to AIDS, HIV INFECTION or HEPATITIS INFECTION.

The above information may be disclosed to or received by:

ATTORNEY
HOSPITAL (ADMISSION)
INSURANCE COMPANY
MEDICARE (CLAIMS ISSUES)
OTHER CARE GIVERS (REFERRALS FOR ADDED CARE)

I also give consent for messages from DOS to be released to:

___ Left on home phone answering machine Phone Number _____
___ Work Voice Mail Phone Number _____
___ Spouse Name of Spouse _____
___ Child Name of Child _____
___ Other Name and Relationship _____

I prefer to be contacted at:
___ Work Phone Number _____
___ Home Phone Number _____
___ Other Phone Number _____

I understand that this this consent will remain a permanent part of my medical record and that does not expire. I also understand that I may, at any time, revoke this consent, or any part thereof, in writing. I understand that DOS will do all in their power to see that any personal information is maintained in a professional manner and only released to those that it deems appropriate to receive said information. I also understand that DOS is required by Law to maintain the privacy of, and provide individuals with, this notice of their legal duties and privacy practices with respect to PHI. If you have any objections to this form, please ask to speak to our HIPAA Compliance Officer in person or by phone at (302) 633-3555. My signature on this form acknowledges my completion of the above information and that I received a copy of DOS's Notice of Privacy Practices.

Print Name: _____

Signature: _____ Date: _____

Signature of Staff Member: _____ Date: _____