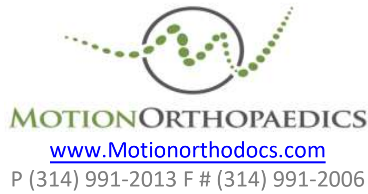

www.Motionorthodocs.com
P (314) 991-2013 F # (314) 991-2006

AUTHORIZATION FOR RELEASE OF INFORMATION OR INDIVIDUAL ACCESS TO INFORMATION

This form allows Motion Orthopaedics to release records from our office and does not allow us to request records from another physician's office.

I hereby authorize Motion Orthopaedics to release medical information of: ____
(Patient's full name)

Former Names (where applicable): ____

Date of Birth: _________________________ For the Purpose of: ____
(For patient request, state "self")

Which doctor are you requesting records from?

Dates of Treatment: ____

Release or Mail to: ____

Address:

Fax to: (314) __________________________________ Phone: (314) 991-2013
(Or see above)

Once this information has been released pursuant to this Authorization, it may no longer be protected by Federal and/or State law/regulations and may no longer be deemed "Confidential". I permit the release of all information indicated above including test results and/or diagnosis and treatment information, if any, concerning drug/alcohol treatment or use, psychiatric treatment or AIDS/HIV and other communicable diseases.

I understand that neither Motion Orthopaedics nor any affiliated healthcare providers can make me sign the Authorization as a condition to getting treatment, making payments on any bills, or gaining enrollment or eligibility in any health insurance plan, unless the Federal Privacy Regulations allow it. I agree that I have received a signed copy of this Authorization if I chose to do it.

I understand that I may revoke this Authorization at any time except to the extent that prior action has been taken in reliance on this authorization, This Authorization will expire ninety (90) days from the date it is signed if I do not cancel it in writing prior to the expiration date. I understand that if I want to cancel/revoke this Authorization, I must mail, fax or bring a letter in person stating that I want to cancel this Authorization. I understand that I need to mail, fax or bring the letter to the address or fax number noted at the top of the page.

Patient/Legal Representative Signature:____

By checking this box I affirm my intent to sign this form electronically by typing my name above.

Date:____Relationship:____