Mountain Valley ORTHOPEDICS

THE STRENGTH OF EXPERIENCE

Authorization to OBTAIN or RELEASE Medical Records

(Print Patient's Full Name) (Birth Date; Mo/Day/Year)

(Street Address) (Social Security Number)

(City, State, Zip Code) (Daytime Phone #)

At the request of the individual, I _____, do hereby authorize Mountain Valley Orthopedics to
___ **RELEASE** ___ **OBTAIN:**

___ Progress Notes
___ Laboratory Reports
___ Consult Reports
___ MRI Reports
___ Radiology Reports
___ CT Scans/Bone Scans/EMG
___ Physical Therapy Reports
___ Operative Notes
___Other_____
_____
_____
_____

Authorize the release of information pertaining to the following:

___ I do ___ I do Not have AIDS, HIV, or any other communicable disease
___ I do ___ I do Not use drugs and/or alcohol
___ I do ___ I do Not have a psychiatric or psychological assessment

Information Released TO:

Mountain Valley Orthopedics
600 Plaza Court, East Stroudsburg, PA 18301
Phone: (570) 421-7020 Fax: (570) 421-7091

Information Released TO / FROM:

_____
Name of Company, Agency Facility or Person

_____
Street Address

_____
City, State, Zip

Phone # _____ Fax #_____

Purpose of Disclosure:

___ Referral to Specialist ___ Insurance ___ Worker's Comp ___ Change of Doctor ___ Legal Investigation
___ Disability Determination ___ Personal ___ Continuing Care ___ Other (Specify)_____

I hereby authorize disclosure of the health information for the above named patient. This authorization is valid 12 months from the date of signature. I understand that I may cancel this request in written notification, but that it will not effect any information released prior to notification of cancellation. I understand that the information used or disclosed may be subject to re-disclosure by the person or class of person or facility receiving it, and would then no longer be protected by federal regulations. I understand that the medical provider by whom this authorization is furnished may not condition their treatment of me on whether or not I sign the authorization.

_____ _____

Signature of individual or guardian or Personal Representative of patient's estate **Date**

NOTE: There will be a charge for a personal copy or the permanent transfer of your records.
Fax: (570) 421-7091, rev 11/15 (FOR OFFICE USE ONLY: Completed and logged in patient chart by: _____)