

KSF Orthopaedic Center, PA

Name of Patient: _____

Patient DOB: _____ For Office Use: Acct No. _____

Section I. If you wish us to discuss your treatment or release records to any individual who may call or write to us, please fill out this section. I hereby authorize KSF ORTHOPAEDIC CENTER to release information from my medical record as indicated above to:

- Please give us your primary care physician's name and number if you authorize our sharing your medical information with him/her. Dr. _____ at _____ (phone number).

Below list spouse, relatives, or friends that you would like us to release information to:

Name: _____

Address: _____

Day Phone: _____ Evening Phone: _____

Fax #: _____ Email Address: _____

Name: _____

Address: _____

Day Phone: _____ Evening Phone: _____

Fax #: _____ Email Address: _____

Dates authorization to remain in effect: _____

I specifically authorize the release of information relating to:

- All records, including HIV and Mental Health records
- History and Physical exam Progress notes Billing records
- Lab reports Mental health X-ray reports
- HIV related information (AIDS related testing)

Patient/Legal Guardian Signature _____ **Date:** _____

Section II. If you do not wish us to release any information to anyone please fill out this section. I do not wish my medical treatment information to be discussed with anyone besides myself. This includes not giving my medical treatment information to any family members.

Patient/Legal Guardian Signature _____ **Date:** _____

Remember, if you send a properly filled out record release authorization form at a later date, we will honor that release. Records and information will be automatically released to your insurance company in order for KSF to bill your insurance company.