Consent For Release of Confidential Information

PATIENT NAME: ____

PATIENT ADDRESS: ____

____

PHONE: ____

I hereby authorize: ALL-STAR ORTHOPAEDICS AND SPORTS MEDICINE___________

To release to: ____

Address: ____

The following medical, surgical and radiology information on the above named patient(s):

O Progress Notes O X-Ray Reports O X-Ray Films O MRI Films

O MRI Reports O Office Notes O Other ____

Dates of Treatment: ____

Purpose for which this information is being released:

____

____

I understand that my records are protected under Federal Confidentiality regulations Disclosure Act 42CFR Part 2, and cannot be disclosed without my written consent unless otherwise provided for in the regulations. I also understand that I may revoke this consent at any time except to the extent that action has been taken in reliance on it (i.e., probation, parole, etc) and that in any event this consent expires automatically as described below.

This authorization will expire ninety (90) days from the date of my signature unless otherwise specified as follows: ____.

________________ ____

Date **Signature of Patient or Legal Representative**

________________ ____

DOB **Social Security**