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Orthopedic Physician Assistant

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Orthopedic Physician Assistant

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Orthopedic Physician Assistant

Thomas Walsh, PA-C
Orthopedic Physician Assistant

AUTHORIZATION FOR RELEASE OF MEDICAL INFORMATION

I hereby authorize Orthopedic Surgery, Inc DBA Agility Orthopedics to use or disclose the following protected health information from the medical records for the patient listed below. I understand that information used or disclosed pursuant to this authorization could be subject to redisclosure by the recipient and, if so, may not be subject to federal or state laws

Patient Information: MR#:______________

Name ______________________________ DOB: ____________________

Address ____

____________________________________ Phone # _________________

Purpose of Request:

Medical Treatment _______________________
Other (please provide reason) _________________

Information to be released:

Office notes: Dates: From__________ to__________
Other specific reports:

____

____

I authorize Orthopedic Surgery, Inc. DBA Agility Orthopedics to release copies of my medical records to:

Name: ____
Address:

____

____

____

Phone: __________________________

I understand I may revoke this authorization at any time by requesting such of the above referenced hospital/physician practice in writing, unless action has already been taken in reliance upon it, or during a contestability period under applicable law.

This authorization expires on (upon) _________________________

Signature: ____

(Parent/Legal Guardian relationship)