AUTHORIZATION TO DISCLOSE PROTECTED HEALTH INFORMATION

Patient N	lame		Date of Birth				
Address_					hone		
□ Please	Street process this authorization now.	-	State s authorization o	Zip on file for possi	ble disclosure later.		
		•		-		A. dies I Clinia	
	ORIZE: □ Madison Memorial	_			_		
□ Madis	on Memorial Orthopedics \square S	easons Medical by M	Iadison Memori	al 🗆			
TO DISC	CLOSE TO:						
Address		City	State	Zip c	ode	Fax Number	
The follo	owing type(s) of information pe	r this authorization	:				
Any	information concerning the patient's	health, health care, or pa	nyment during the	relevant time peri	od.		
Only	y the following health records from the	e relevant time period:					
	History & Physical	Last PO Intake		Radiology Rep		L	
	Nurses Notes	Operative Report		Radiology Imag	ges		
	Pathology Report	Discharge Summa	•	EKG			
	Physician's Progress Notes	Physician's Orders		Lab Reports			
	Emergency Room Record	Consultation Repo		Office Notes			
	ing and payment records for care rend er:	_	_				
Records	or Information relating to the	following time perio	od:				
	The patient's health care at anytime						
	The patient's health care between (a		and (da	ite)			
DUDDO	_				·		
PURPUS	SE or NEED FOR RECORDS: Personal		nant/Cantinuina Ma	dical Cara			
	Personal Treatment/Continuing Medical Care Insurance Disability Request						
	Legal/Attorney/Subpoena		(specify)			_	
FORMA					owing format:		
	Paper format (US Mail)	CD (MMH only)	Fax (Healthcare I	Provider only)			
	Paper format (pickup)	Review Only	Email				
to disclo	IVE NATURE RECORDS: The seinformation (diagnosis/treat cohol, or substance abuse, Hiton.	tment) regarding be	havioral/menta	al health condi	itions (excluding psy	chotherapy notes)	
understar	voke this authorization in writing that the revocation will not a deer my policy. Unless otherw It	pply to my insurance rise revoked, this a	company when uthorization will	the law provious the law provious the thick the law provides the law provi	des my insurer with t	the right to contest a	
informati	date this authorization is dated. ion is disclosed to others, the pro- isurance Portability and Account	otected health inform	ation may be dis	sclosed to indiv	viduals or organizatio		
Signature	of Patient or Legal Representative		Date				
& reason f	by Legal Representative, state legal for representation.			are of Witness			
Facility Us	te Only: □ Authorizer's ID Verified	☐ ID of 3 rd Party Receivi	ng Records Verified	Completed by:			
Records rec	quested from:		Ph	none:	Fax:		
Address:			City		State	Zip	
	sed://						