SWSMO MEDICAL RECORDS RELEASE

I hereby authorize _____ to release my medical records to:

PHYSICIAN:_____

ADDRESS:_____

CITY STATE ZIP:_____

PURPOSE OR REASON:_____

_____IF RELEASED TO PATIENT: I understand that my records may contain reports, tests results and notes that only a physician can interpret and understand that I should contact my physician regarding the entries made in my medical record to prevent my misunderstanding of the information written the record. I will not hold Southwest Sports Medicine & Orthopaedics liable for any misinterpretation of the information in my medical record as a result of not consulting my physician for the correct interpretation.

Check one:
[ ] I understand that my records may contain information regarding the diagnosis or treatment of HIV (AIDS virus), or other sexually transmitted diseases, drug and/or alcohol abuse, mental illness or psychiatric treatment. I give my specific authorization for these records to be released.

OR

[ ] I do not give my permission to release information regarding the diagnosis or treatment of HIV (AIDS virus), other sexually transmitted diseases, drug and/or alcohol abuse, mental illness or psychiatric treatment.

This authorization given herein shall be deemed to continue until withdrawn by me in writing. Any photostatic copy of this authorization shall be as valid and effective as the original.

PATIENT:_____

ACCOUNT #:_____ DATE OF BIRTH:_____

ADDRESS_____

CITY STATE ZIP_____

SIGNATURE:_____DATE_____

WITNESS:_____DATE_____