Cincinnati SportsMedicine and Orthopaedic Center, Inc.

F65 (06/2012)

10663 Montgomery Road, Cincinnati, OH 45242
12115 Sheraton Lane, Cincinnati, OH 45246
7423 Mason-Montgomery Road, Mason, OH 45040
6350 Glenway Ave. Ste. 415, Cincinnati, OH 45211
328 Thomas More Parkway, Crestview Hills, KY 41017

Five offices, One number (513) 347-9999
www.cincinnatisportsmed.com

AUTHORIZATION FOR RELEASE OF MEDICAL INFORMATION

Patient Name: ☐ Date of Birth: ☐

Address: ☐

City, ST, ZIP ☐

SSN: ☐ Patient Phone Number ☐

Date of Request: ☐ Date Needed: ☐

☐ I authorize the Cincinnati SportsMedicine & Orthopaedic Center to release information to:

Name of provider:
Address:
City, ST, ZIP
Phone #:
Fax #:

☐ I authorize the Cincinnati SportsMedicine & Orthopaedic Center to obtain information from:

Name of provider:
Address:
City, ST, ZIP
Phone #:
Fax #:

PURPOSE FOR THIS REQUEST: ***(Check one)*** ☐ Healthcare ☐ Ins. coverage ☐ Personal ☐ Other ☐ Transfer of care

TYPE OF RECORDS REQUEST: ***(Check one)***

☐ All medical records related to a specific illness or injury. *Below, please list the specific illness/injury and dates of treatment.*

☐ Specific information *Select one or more, as applicable.*

- ☐ Procedure report
- ☐ History and Physical
- ☐ Physical Therapy
- ☐ Laboratory test results
- ☐ Operative reports
- ☐ X-ray reports

☐ Entire copy of the record checked above.

AUTHORIZATION VALID FOR: ***(Check one)***

☐ This request only.

☐ One year from the date of this authorization OR ___________________________(insert date). This authorization applies to the records of the treatment received on or prior to the date of this authorization.

☐ This request and for medical records of any future treatment of the type described above until: _________________ (insert date)

***** CONTINUED ON OPPOSITE SIDE *****

I understand that:

My right to health care treatment is not conditioned on this authorization.

I may cancel this authorization at any time by submitting a written request to the address provided at the top of this form, except where a disclosure has already been made in reliance on my prior authorization.

If the person or facility receiving this information is not a health care or medical insurance provider covered by privacy regulations, the information stated above could be re-disclosed.

There may be a charge for the requested records.

***** MEDICAL RECORDS ARE FAXED ONLY IN CASES OF MEDICAL NECESSITY *****

Signature of patient or representative: ____________________ Date: __________

Relationship to patient *(if requestor is not the patient)* ____________________

Signature of witness: ____________________ Date: __________

Witness Name: ____________________

Distribution : Original to medical record. Copy to requester, as required.