ORTHOPAEDIC ASSOCIATES OF MICHIGAN

1111 Leffingwell NE, Grand Rapids, MI 49525
Phone: (616) 459-7101 Fax: (616) 336-5042

Release of Information
Today's Date: _____ **(Initials):** _____

Received by

Patient's Full Name _____ **Date of Birth** _____

Daytime Phone: _____ **Email Address** _____

Mailing Address (Street, City, State, Zip) _____

I hereby authorize records FROM:

Orthopaedic Associates of Michigan
1111 Leffingwell, NE
Grand Rapids, Michigan 49525
PHONE: (616) 459-7101 FAX: (616) 336-5042

To be Released TO:

☐ Patient
☒ Other (Please complete name and address below)

Fax or mail completed forms to:

RECORDS DEPOSITION SERIVCE, INC.
PO BOX 5054, SOUTHFIELD, MI, 48086-5054
PHONE #: 248-357-3330 **FAX #** 248-357-3337

Purpose of Disclosure: PRE TRIAL DISCOVERY

	Self/Personal Copy		*Transfer or Continuity of Care*
	Litigation		*Disability*
	Insurance		*Work Comp*
	Other _____		

Description of Disclosure:

	Physician Office Notes		*X-Ray/MRI Reports*
	Op/Procedure Reports		*Lab/Path Reports*
	Other _____		

Date Range: From: _____ To: _____

You are responsible to pay the copy charges fee prior to the release of records.

- I understand that the information in my medical record may include information relating to sexually transmitted disease, acquired immunodeficiency syndrome (AIDS), or human immunodeficiency virus (HIV). It may also include information about behavioral or mental health services, and treatment for alcohol and drug abuse.
- This authorization will expire one year from the date your signature below, unless you specify an earlier termination date. You must renew or submit a new authorization after the expiration date to continue the authorization. Please list the date of expiration if earlier than one year from the date of execution of this document: _____
- You have the right to revoke or terminate this authorization at any time by submitting a written request to our Privacy Manager. Termination of this authorization will be effective upon written notice, except where a disclosure has already been made based on prior authorization.
- The practice places no condition to sign this authorization on the delivery of healthcare or treatment.
- We have no control over the person(s) you have listed to receive your protected health information. Therefore, your protected health information disclosed under this authorization may no longer be protected by the requirements of the Privacy Rule and will no longer be the responsibility of the practice.

I have read the information provided on this release form and do hereby acknowledge that I am familiar with and fully understand the terms and conditions of this authorization.

Patient or Representative Signature _____ Date _____

Printed Name _____ Relationship ("Self" or Authorized Representatives Only*) _____

*Legal paperwork for authorized representatives, including biological/adoptive parents, legal guardians and medical powers of attorney, must be on file.