Medical Records Release

Please Print Clearly & Fill-in All Sections Completely

Patient's Name:_____ Date of Birth:_____

Address (street, city, state & zip code):_____ Last Four of SSN:_____

I authorize Orthopedic Associates of SW Ohio and/or the Hand Center of Southwestern Ohio, custodian of my medical records, to disclose/release the following Protected Health Information: (please check all that apply)

☐ All records ☐ Operative Reports ☐ Progress Notes ☐ X-ray/radiology records

☐ Billing records ☑ Other PLEASE SEE THE ATTACHED SUBPOENA OR LETTER REQUEST

OR: Release ONLY the specific dates of service as listed:_____

*Note: If these records contain any information from previous providers or information about HIV/AIDS status, cancer diagnosis, drug/alcohol abuse, or sexually transmitted disease, you are hereby authorizing the disclosure of this information.

Please send the records indicated above to:

Name:	RECORDS DEPOSITION SERVICE, INC.	Name:	
Address:	P.O. BOX 5054 SOUTHFIELD, MICHIGAN 48086-5054	Address:	
Phone:	248-357-3330	Phone:	
Fax:	248-357-3337	Fax:	

The information being requested is for (please mark all that apply):

☐ Second Opinion
☐ Specialist Care
☐ Permanent Transfer of Care
☑ Legal (Specify) FOR DISCOVERY BEFORE TRIAL
☐ Temporary Transfer of Care (Indicate Dates)_____
☐ Other (Specify)_____

This authorization is valid for one-hundred-eight (180) days from the date it is signed. I understand that after the custodian of records for Orthopedic Associates of SW Ohio and/or the Hand Center of Southwestern Ohio discloses my health information, it may no longer be protected by federal privacy laws. I certify that this request has been made freely, voluntarily and without coercion and that the information given above is accurate and complete to the best of my knowledge and that I may refuse to sign this authorization. My refusal to sign will not affect my ability to obtain treatment; receive payment; or eligibility for benefits unless allowed by law. I may revoke this authorization in writing, at anytime. I understand that a revocation of this authorization has no effect on records that have already been disclosed in response to authorizations received prior to the written notice of revocation. Written revocation is effective upon receipt by the Medical Records Department of Orthopedic Associates of SW Ohio. By signing below I represent and warrant that I have authority to sign this document and authorize the use or disclosure of protected health information and that there are no claims or orders pending or in effect that would prohibit, limit or otherwise restrict my ability to authorize the use or disclosure of this protected health information.

_____ _____

Signature of patient (or patient's representative) *Date*

_____ _____

Printed name of patient or patient's representative *Representative's authority to sign for patient (i.e. parent, guardian, power of attorney for healthcare)*

All records will be mailed by Healthport to address listed above. Please allow 30 days for completion.

Signature OASWO Witness: _____ Date: _____

Printed name of OASWO Witness: _____

(Revised 10/3/14)