Woods Mill Orthopedics, LTD
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I, the undersigned, authorize the company and/or individual selected below to release my private health information.

◯ Woods Mill Orthopedics physicians or any representatives of Woods Mill Orthopedics.
◯ Dr. _____
Adress: _____
City, State, Zip: _____

Please forward my private health information to the selected company and/or individual below:

◯ Woods Mill Orthopedics physicians or any representatives of Woods Mill Orthopedics.
◯ Dr or individual _____
Adress: _____
City, State, Zip: _____

Purpose of disclosure: _____

Information to be released, a clear and meaningful description is required by law:
◯ Record of Visits ◯ Progress Notes ◯ Consultation Notes ◯ Diagnostic Tests ◯ EKG's
◯ Billing Records ◯ Lab Results ◯ Operative Reports ◯ Signed Orders ◯ X-Rays
◯ Other _____

I do ___ do not ___ authorize release of information related to AIDS, HIV infection, psychiatric care and/or psychological assessment, and treatment for alcohol and/or drug abuse.

A photo copy of this authorization is to be considered as valid as the original. The authorization is valid for 90 days from the date of signature. I understand that I may cancel this request with written notification but that it will not effect any information released prior to notification of cancellation. I understand that the information used or disclosed may be subject to re-disclosure by the person or company receiving it, and would then no longer be protected by Federal law. I also understand that any hard copy x-ray released to me are the originals and I am responsible to return them to Woods Mill Orthopedics. If hard copy x-rays are not returned, Woods Mill Orthopedics can not reproduce a new copy. This will not be the case with digital x-rays done after April 1, 2011.

Last Name, First Name, Middle Initial of Patient: _____
Patient Adress, City, Zip: _____
SSN: _____ Date of Birth: _____ Daytime Phone: _____

Signature of Patient or Legal Representative: _____
Printed Name of Patient or Legal Representative: _____Date:_____