Summit Orthopaedics | Go To Ortho
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RELEASE OF INFORMATION FORM

AUTHORIZATION TO USE OR DISCLOSE HEALTH INFORMATION

I authorize: _____
(Name of physician or group – example: Summit Orthopaedics)

to use and disclose a copy of the specific health and medical information described below regarding:

_____ _____
(Name of patient) *(Date of Birth of patient)*

consisting of : _____
(Describe information to be used/disclosed – example: all medical records, x-rays only, etc)

to: _____
(Name and address/fax number of recipient – example: where you want records sent)

for the purpose of : _____
(Describe why – example: continuation of care, attorney, personal records, etc)

Your health care and payment for that health care cannot be conditioned upon receipt of this signed Authorization Form unless your health care or treatment is for the purpose of:

1. Creating health information about you to be disclosed to a third party; or
2. For the purpose of research.

You have the right to revoke this Authorization Form at any time, provided that you do so in writing. If you revoke your Authorization, we will no longer use or disclose information about you for the reasons covered by your written Authorization, but we cannot take back any uses or disclosures already made with your permission. To revoke this Authorization, please send a written statement to the Privacy Officer at Summit Orthopaedics, LLP, 4103 Mercantile Dr., Lake Oswego, OR 97035 that identifies the date you sign this Authorization, the recipient of the information identified in this Authorization, and state that you are revoking this Authorization.

This Authorization will expire on the earlier of _____ (date), 180 days from the date of signing, or the end of the period reasonably needed to complete the disclosure for the above-described purpose.

I have reviewed and I understand this Authorization. I also understand that the information used or disclosed pursuant to this Authorization may be subject to re-disclosure by the recipient and no longer be protected under Federal law. Please note: There is a $30 charge for copies of your records unless they are being forwarded to another physician for continuation of care.

Patient Signature: _____ Date: _____

-or-

Patient Representative Signature: _____ Date: _____

Description of Representative Authority: _____

Updated 12/4/23