Wooster Orthopaedic & Sports Medicine Center

AUTHORIZATION TO DISCLOSE HEALTH INFORMATION

3373 Commerce Parkway, Ste 2
Wooster, OH 44691
Phone: 330-804-9712
Fax: 330-804-9811
Toll Free: 800-800-5240

1261 Wooster Rd., Ste 120
Millersburg, OH 44654
Phone: 330-674-0775
Fax: 330-674-0786
Toll Free: 866-674-0775

Smucker Building Wing
830 S. Main St, Ste 103
Orrville, OH 44667
Phone: 330-684-4772
Fax: 330-684-4799

_____ _____ _____
Name of Patient | Date of Birth | Phone Number

_____ _____ _____ _____
Street Address | City | State | Zip

AUTHORIZATION TO RELEASE INFORMATION

PLEASE **OBTAIN** INFORMATION **FROM**:

_____
Name of Doctor or Health Care Facility

_____
Street Address

_____ _____ _____
City | State | Zip

_____ _____
Phone | Fax

PLEASE **SEND** INFORMATION **TO**:

_____
Name of Doctor or Health Care Facility

_____
Street Address

_____ _____ _____
City | State | Zip

_____ _____
Phone | Fax

I AUTHORIZE the following information to be disclosed:

Records needed for what body part? *(example: knee, lower back, shoulder, etc.)*

_____

Records needed *(check all that apply)*

☐ Clinic Notes ☐ X-ray Reports ☐ X-ray Copies ☐ Lab Work

☐ Other _____

Reason for disclosure of health information *(must provide)*

☐ Relocation ☐ Medical Necessity ☐ Second Opinion ☐ Insurance Change ☐ Our Referral

☐ Medical Records Request ☐ Other _____

Please release the records in the following format: ☐ Patient Portal ☐ Fax ☐ Paper

My current appointment date is _____

Signature of patient/authorization person _____ Date _____

Signature of witness _____ Date _____

EXPIRATION of this Authorization: *(Please choose one)*

☐ 90 days after signature date ☐ On the following date _____

When the following event happens _____

Staff Preparing (initials) _____ *Date*_____ *Pick up Initials* _____ *Date* _____