Seaview Orthopaedics Records Service
Services provided by Med Request Solutions Inc. 800-483-6040 x2
Email:requests@medrequestsolutions.com

AUTHORIZATION TO RELEASE HEALTHCARE INFORMATION

Patient's Name: _____ Date of Birth: _____

Previous Name, if any: _____ Social Security #: _____

I request and authorize Seaview Orthopaedics & Medical Associates to release healthcare information of the patient named above to:

Name: _____

Address: _____

City: _____ State: _____ Zip Code: _____

This request and authorization applies to:

☐ Healthcare information relating to the following treatment, condition, or dates: _____

_____

☐ Physical Therapy Treatments, specify dates:_____

☐ Other:_____

Indicate purpose: At individual's request/other: _____

Authorization re: sensitive information: To the extent applicable, I understand that my medical record may contain information that is considered sensitive under the law. My check mark(s) below indicate(s) that I do **NOT** permit information of this type, if it exists, to be released. I understand that if I do not check the box, Seaview Orthopaedics will release such information about me if it exists.

☐ HIV/AIDS
☐ Genetic Information
☐ Mental Health ☐ Psychotherapy Notes
☐ Sexually Transmitted Diseases
☐ Treatment for alcohol and/or drug abuse

- I understand that:
  - this authorization will expire in one (1) year from the date signed below
  - I may revoke this authorization by notifying Seaview Orthopaedics but that any previously disclosed information would not be subject to such revocation
  - I may refuse to sign this authorization and that my refusal to sign will not affect my ability to obtain treatment, payment, enrollment or my eligibility for benefits, unless otherwise described in the space provided here:_____
  - there is a potential for the information disclosed to be subject to re-disclosure by the recipient if the recipient is not required by law to protect its privacy.

Patient Signature:_____ Date Signed:_____

Personal Representative Signature:_____Authority:_____

Date Signed: _____ _____