ORTHOPEDIC & SPORTS INSTITUTE OF THE FOX VALLEY™

For Internal Use Only
MRN:

Orthopedic and Sports Institute of the Fox Valley (OSI)
Authorization to Release Protected Health Information Form

Please forward this completed form to OSI to process.

Your Doctor / Care Team:

❑ Valley Orthopedic Clinic ❑ OCA, SC (Orthopedic Clinic of Appleton) ❑ Orthopedic and Sports Surgery Center

Patient / Subscriber Information:

Last First Middle Maiden/Other Telephone Number

Address City State Zip Date of Birth

I authorize and give my permission for:

Organization/Individual and type of provider/person

Street Address

City State Zip

To release my protected health information described below to:

Organization/Individual (attention to:)

Street Address / Fax number / Other

City State Zip

Method to release my protected health information (PHI):

❑ Verbal ❑ Fax ❑ US mail ❑ Pickup (in person) ❑ Other (specify): _____

Information (PHI) to be released: **Date From:** **Date To:**

❑ Clinic notes ❑ Implant records ❑ Billing records
❑ Surgical report/notes ❑ Anesthesia records ❑ X-ray/MRI/Imaging Reports
❑ Prescriptions ❑ X-ray / MRI / Image ❑ Other:

The purpose(s) of this release is:

❑ Further medical care ❑ Disability determination ❑ Insurance purposes
❑ Workers Compensation ❑ Personal use ❑ Other (please explain): _____

This authorization to release my protected health information (PHI) is effective until the following expiration date or event _____. If I do not list an expiration date or event, this authorization will expire one year from the date signed.

I am not required to sign this form in order to be provided treatment, payment, enrollment in a health plan, or eligibility for benefits. The persons(s) I am authorizing to receive my PHI may release my PHI without my knowledge and may not be required to follow federal or state privacy standards. I may be charged a fee before I receive copies of my PHI. I understand if Orthopedic and Sports Institute of the Fox Valley (OSI) is not able to provide a copy in the format requested, I will be contacted to discuss other options.

I may cancel this authorization to release my PHI by completing and sending OSI's Cancel and Authorization to Release PHI form to OSI. Cancellation does not apply to PHI already released in response to this authorization. Cancellation does not apply to my insurance company as needed to contest a claim under my policy.

I understand what PHI about me will be released. I read and understand this form. This accurately reflects my wishes.

Signature of Patient or Legal Representative* Date

***Name of the Legal representative completing this form:** _____

Legal authority*: ❑ Parent **By signing above, I am confirming that I have not been denied physical placement of this child
❑ Legal guardian ❑ Next of kin / executer of deceased ❑ Activated POA for Health Care ❑ Other: _____

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For OSI's Internal Use Only			
Date received:		❑ **Copy of this form was provided to individual**	
Description of PHI released: **PHI Released by:**			
Name of workforce member	Title	Signature	Date & time released

Original: chart Copy: Patient/legal representative