Norris, Blessinger & Woebkenberg
Orthopaedics & Spine
1900 Saint Charles Street • Jasper, IN 47546 • 812-634-1211

Authorization for Release of Protected Health Information

____From another physician/entity ____To another physician/entity ____To a designated person
(Please check one)

Name of Patient: _____

Address: _____ **Phone Number:** _____

_____ **Date of Birth:** _____

_____

I request and authorize the disclosure/release of my protected health information- listed below- to the following person/provider. **List below (name and address or fax number of person or institute you want to receive the records).**

_____

Information should be: Mailed ____ Faxed ____ Call when available ____

Purpose of disclosure- general purpose or intended use of medical records (why records are needed):

_____

____ Complete medical record ____ Only information listed below

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I, the undersigned, understand that I may REVOKE this authorization at any time, in writing, but the request shall remain valid until revoked or upon the expiration of sixty (60) days, whichever occurs first, EXCEPT to the extent that action has been taken thereon. I understand that I am giving permission to release all medical information from Norris, Blessinger & Woebkenberg Orthopaedics & Spine. **X-ray films are not covered under this release.** I also understand that if there is a charge for the production of these medical records, I will be responsible for the payment.

(Signature and Date REQUIRED by law to validate form)

_____ _____

***Signature (as designated by law)** Printed Signature

_____ _____

Relationship (If other than patient) Date of Signature (REQUIRED)

_____ _____

Witness/ Office Staff Initials Desired Date for Records

*****To Speed up the processing time of this form, please ensure all necessary (bolded) information is completed. Thank You!**

Office Use Only!
Released By: _____ Date: _____