LAKESHORE
BONE & JOINT INSTITUTE
ORTHOPEDIC EXCELLENCE. KEEPING YOU IN MOTION.

Authorization for Release of Medical Information

Patient Name: ______________________________ Date of Birth: ________________________Acct #:______________
Address: ________________________________ City/State/Zip Code: ______________________________________
Best Contact Number: ________________________ Date of Request: ________________Date Needed:_______________

I hereby authorize___________________________________**(print name or provider) to release information from my medical record as indicated below to:**

Name: ____
Address: ______________________________________ City/State/Zip Code: __________________________________
Phone Number: __________________________________ Fax Number: ______________________________________

Information to be released: **Date(s) of Treatment:** ____
□ MRI image □ X-Ray image □ Copy of entire medical record as allowed by law

Specific Information (select all that apply):
□ Procedure note □ History & physical □ Lab results □ MRI report □ X-ray report
□ Physical/occupational therapy note □ Other:__________________

I SPECIFICALLY AUTHORIZE THE RELEASE OF INFORMATION RELATING TO:
□ SUBSTANCE ABUSE (including alcohol/drug abuse)
□ MENTAL HEALTH (including psychotherapy notes)
□ HIV RELEATED INFORMATION (AIDS related testing)

X____
(Signature of Patient or Legal Guardian)

RECORDS WILL BE PLACED ON: (check one) □ CD □ Paper

The purpose of this disclosure: (check one)
□ Continuation of care □ Personal □ Legal □ Transfer of care □ Other

AUTHORIZATION: I understand that this authorization will expire on ____
If I do NOT specify expiration, this authorization will expire one year from the date signed.

I understand that:
- My right to healthcare treatment is not conditioned on this authorization.
- I may cancel this authorization at any time by submitting a ***written*** request to 601 Gateway Boulevard, Chesterton, IN 46304, except where a disclosure has already been made in reliance to my prior authorization.
- Revocation will not apply to my insurance company when the law provides my insurer with the right to contest a claim under my policy.
- If the person or facility receiving this information is not a healthcare or medical insurance provider covered by privacy regulations, the information stated above could be redisclosed.
- There may be a charge for the requested records

Signature of Patient or Representative:_______________________________________ **Date:**____________________
Relationship to Patient (if the requestor is not the patient):____

Lakeshore Bone & Joint Institute complies with applicable Federal civil rights laws and does not discriminate on the basis of race, color, national origin, age, disability, or sex.