ALIGNED ORTHOPEDIC PARTNERS

AUTHORIZATION FOR RELEASE OF MEDICAL RECORDS

I authorize Aligned Orthopedic Partners and/or AOP Physical Therapy to release records to:

Name	Phone
Street Address	Fax
City, State, Zip Code	E-mail

Records to be released:

□ Office Visit Notes	□ Physical Therapy Records
□ Operative Reports	□ Radiology Images
□ Diagnostic Study Reports (Labs, MRI, EMG, CT, etc)	□ Itemized Billing Statement

Treating Physician	Body Part	Dates of Services

Patient Information:

Name	Date of Birth
Daytime Phone Number	Signature Date

Please indicate your acceptance by checking the following boxes:

□ I understand that I may revoke this authorization in writing at any time except to the extent that action has been taken in reliance upon this authorization (45 CFR § 164.508(c)(2)(i)).

□ I understand that treatment or payment cannot be conditioned on my signing this authorization, except in certain circumstances such as for participation in research programs, or authorization of the release of testing results for preemployment purposes (45 CFR § 164.508(c)(2)(ii)).

□ I understand that my records are confidential and cannot be disclosed without my written authorization except when otherwise permitted by law. Information used or disclosed pursuant to this authorization may be subject to redisclosure by the recipient and no longer protected. I understand that the specified information to be released may include, but is not limited to history, diagnosis, and/or treatment of drug or alcohol abuse, mental illness, or communicable disease, including Human Immunodeficiency Virus (HIV) and Acquired Immune Deficiency Syndrome (AIDS) (45 CFR § 164.508(c)(2)(iii)).

This authorization will expire One Hundred Eighty (180) days from the date of my signature unless I revoke the authorization prior to that time.