MARTIN & SUHEY ORTHOPEDICS

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CONSENT FORM for RELEASE OF MEDICAL INFORMATION

Patient Name:			
Patient Address:	City:	State:	Zip Code:
DOB:	Social Security #: - -		
I hereby authorize:			
To release the requested portions of my medical records to: **Martin & Suhey Orthopedics** 911 University Drive State College, PA 16801			
Release Purpose:			

Medical Records Copies Requested
May include but not limited to:

Office Visit Notes ☐	Past Medical History ☐	Correspondence from other physicians ☐
Operative Report ☐	Work/Disability Status ☐	Physical Therapy Reports ☐
Lab Results ☐	Treatment Plan ☐	School/Event Participation Status ☐
X-ray File/Reports ☐	Current Diagnosis ☐	Other

THE FOLLOWING INFORMATION IS PROTECTED BY STATE AND FEDERAL LAW
Please *initial each box* indicating you are aware this information may be released.

HIV (act 148) inti	Alcohol or Drug Abuse inti	Psychiatric initi

Authorization Period

This authorization shall be valid from:	Effective Date (Today):
	Ending Date:

I understand that this consent may be revoked by me, in writing, at any time, except to the extent that action has been taken in reliance upon it. I also acknowledge the information disclosed pursuant to this authorization may be subject to re-disclosure by the recipient and no longer protected by federal law.

PATIENT'S SIGNATURE:	Date:

IF A PATIENT IS UNABLE TO SIGN CONSENT OR IS A MINOR, COMPLETE THE FOLLOWING:

Patient is a minor ☐		Year of Age:	
Patient unable to sign consent ☐		Reason:	
Signature of Parent/Legal Representative:		Date:	

Relationship:	Parent: ☐	Legal Guardian: ☐		Other: ☐	