M&M ORTHOPAEDICS

Extraordinary Outcomes

For Office Use Only
Chart# ______________
Physician ______________
Fee ______________
☐ Paid (Initials) ______________
☐ Need to Collect Fee (Initials) ______
☐ Notify when sent (Ph.#) __________

AUTHORIZATION FOR DISCLOSURE OF PROTECTED HEALTH INFORMATION

I, ____

Name of Patient   Date of Birth

hereby authorize M&M Orthopaedics to disclose my records/information to:

Name: ____

Address: ____

City, State, Zip Code: ____

Fax Number: ______________________ E-Mail: ______________________

Information and dates of information to be released: (Please check ALL that apply)

From (date): ______________________ To (date): ______________________

☐ Complete Medical Record   ☐ X-Rays ______________________ (specify body part)

☐ Office Notes   ☐ MRI Report

☐ Operative Report   ☐ MRI CD ______________________ (specify body part)

☐ FMLA   ☐ Billing Record

☐ Disability Form   ☐ Other

Purpose of Disclosure:

- ☐ Healthcare Provider
- ☐ Self
- ☐ Insurance/Employer
- ☐ Attorney

Date: ______________________

X ____

Patient Signature (Parent/Guardian if Patient is a Minor)

Relationship: ______________________

Please Print Name

____

This authorization will remain in effect for six months from the date signed.

mkm
06/19/2009