Central Texas Orthopaedic Clinic

2117 S. Clear Creek Road
Killeen, Texas 76549
Phone: 254-526-0188 Fax: 254-526-0181

Authorization for Release of Information:

I hereby authorize the following information to be released from the medical record of:

Patient Name: ______________________________ Date of Birth: ______________________
Social Security Number: __________________________________

This Information is to be Released:

To: ___________________________________ From: _____________________________

___________________________________ _____________________________

___________________________________ _____________________________

Please Check Information to be Released

___Progress Notes	___MRI Report	___Pathology Report
___Lab Report	___History & Physical	___Emergency Rm. Report
___X-Ray Report	___Operative Report	___Other

I understand that to the extent any recipient if this information, as identified above, is not a "covered entity" under Federal of Texas Privacy law, the information may no longer be protected by Federal or Texas law once it is disclosed to the recipient and , therefore, may be subject to re-disclosure by the recipient.

I understand that I may revoke this authorization in writing at any time except to the extent that Central Texas Orthopaedic clinic has already relied on this authorization. I understand that I may revoke this authorization by providing a written request for revocation stating my intent to revoke this authorization.

I understand that Central Texas Orthopaedic Clinic may not condition treatment on my completion of this authorization form.

If information that Central Texas Orthopaedic Clinic is being released directly to me, I understand that my medical record contain reports, test results and notes that only physicians can interpret. I understand that I have been advised that I should contact my physician regarding the entries made in my medical records to misunderstandings of the information that has been written in the record. I will not hold Central Texas Orthopaedic Clinic liable for any misinterpretation of the information in my record as a result of mot consulting my physician for the correct interpretation.

This authorization will expire in 180 days, or at the date or event specified here:_______________________

I understand that the information released for the specific purpose stated above and may not be provided in whole or in part to any other agency, organization, or person.

____ ____________________________
Signature of Patient or legal Representative **Date**

____ ____________________________
Representative's Authority to act for Patient **Witness**