The Christ Hospital
ORTHOPAEDIC ASSOCIATES
Freiberg Orthopaedics
and Sports Medicine

Specializing in:
Arthroscopic Surgery
Disc Surgery
Foot Surgery
Hand Surgery
Pediatric Orthopaedics
Reconstructive Surgery
Scoliosis
Sports Medicine
Total Joint Replacement
Trauma / Fractures

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FOUNDED IN 1890
Entering our third century
of excellent Orthopaedic care.

AUTHORIZATION FOR RELEASE OF INFORMATION

I, the undersigned, hereby authorize The Christ Hospital Orthopaedic Associates -The Freiberg Orthopaedic Group to release a copy of my (or give relationship________________________) medical records or other information regarding my treatment, hospitalization, and/or outpatient care, including psychiatric/psychological conditions, drug or alcohol abuse, drug-related conditions, alcoholism, HIV testing or treatment of AIDS and AIDS-related conditions.

I request that these records be forwarded to:

____
Name
____
Address
____
City, State, Zip   Phone #

The above information is requested to be released for the following purposes only:

REDISCLOSURE OF THE ABOVE INFORMATION REQUIRES SEPARATE WRITTEN AUTHORIZATION.

This statement must be signed and dated, and may be revoked at any time except to the extent action has been taken prior to revocation. This consent will expire in sixty (60) days after the date below, or sooner by my choice, in which case this consent will expire on ________________.

I hereby state that I have read and fully understand the above statements as they apply to me. I hereby consent to the disclosure of the above treatment records.

____
Patient's Name (Please Print)   Maiden Name (if applicable)

____
Address

____
Birthdate

______________________________   ______________________________
Signature of Patient   Date

______________________________   ______________________________
Other person legally authorized to give consent   Witness

____
Relationship to patient and reason