Coordinated Health
SCRANTON ORTHOPEDICS

AUTHORIZATION FOR RELEASE OF INFORMATION **ACCT#** _____

I hereby authorize the use or disclosure of my individually identifiable health information as described below. I understand this authorization is voluntary. I understand that if the organization authorized to receive the information is not a health plan or health care provider, the released information may no longer be protected by federal privacy regulations, and that it may be re-disclosed by the recipient.

Patient Name: _____ **Date of Birth:** _____

Address: _____

Organization Providing the Information: Coordinated Health Scranton Orthopedics

Organization(s) or Person(s) Receiving the Information:

Referring Dr. _____ PCP _____ Disability Insurance. (List Name of Company) _____
Employer _____ Your Employer's Workers' Compensation or Auto Insurance Carrier _____
Other _____

Specific Description of Information Disclosed: All medical care, orthopedic surgical care and treatment, physical therapy and any other professional health care services; any and all medications that have been or will be prescribed to me directly or indirectly related to every condition for which I have received any treatment at CHSO; any and all medications that have been or will be prescribed to me by any physician or health care provider that may be listed within any medical record retained or obtained by CHSO; all diagnoses and treatment provided to me currently and in the past that is part of my medical record; any medical information I have authorized or will authorize any health care provider to disclose to CHSO; patient compliance with provider directives and provider opinions regarding patient conduct. This information may be re-disclosed electronically.

Attention patient: Please complete this section:
I understand that information in response to this request may be related to diagnosis or treatment for AIDS/HIV, psychiatric illness or drug/alcohol abuse. Please check the appropriate lines to indicate understanding:

AIDS/HVI related information	___ No, do NOT Disclose	___Yes, disclose
Mental Health information (*Excludes psychotherapy notes, separate consent required*)	___ No, do NOT Disclose	___Yes, disclose
Drug/alcohol information	___ No, do NOT Disclose	___Yes, disclose

Purpose of Disclosure: _X___ To comply with medical record request; _X___ Providing your employer and insurance company with your current and return to work status, treatment plans, plans of action, diagnosis, prognosis, scheduling information, patient compliance with physician directives, physician opinions regarding patient conduct, and medical status related to your work-related injury. We may also include this information on a summary management report for your employer listing all work-related injuries.

You must read and initial the following statements:

1. I understand this Authorization will expire on 12/31/2022. **Initials**: _____
2. I understand that I may revoke this Authorization at any time by notifying, in writing, any person or entity permitted to disclose information, but if I do, it will not have any effect on any actions they took before they received the revocation. **Initials:** _____

_____
Signature of Patient or Representative

_____ Date_____
Relationship to Patient

You may refuse to sign this Authorization.
We cannot condition treatment on your signing this Authorization

334 Main Street, Dickson City, PA 18519
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