

UTAH ORTHOPAEDIC
SPECIALISTS

5323 South Woodrow Street, Suite 200, Murray, Utah 84107 (801)747-1020 Fax (801)747-1023

*****WE WILL NOT DISCUSS ANY OF YOUR MEDICAL INFORMATION WITH ANYONE UNLESS THIS FORM IS FILLED OUT IN ITS ENTIRETY.*****

AUTHORIZATION FOR RELEASE OF MEDICAL INFORMATION

Date: _____ Patient Name: _____

Patient Date of Birth: _____ Patient Social Security Number: _____

I, _____, hereby authorize Utah Orthopaedic Specialists, LLC to release information from the medical record maintained while I was a patient at Utah Orthopaedic Specialists, LLC.

The information to be disclosed is: (check one)

My entire medical record

Other (specify):

The documents may be released and/or discussed with the following individuals:

Name:

Relation:

I understand that I may revoke this consent at any time in writing, at any time by sending such written notification to Katie Frischknecht at 5323 South Woodrow Street, Suite 200, Murray, Utah 84107 or kfrischknecht@qwest.net; however, such revocation does not affect any actions taken by Utah Orthopaedic Specialists before Utah Orthopaedic Specialists received my written revocation. This consent will automatically expire without my express revocation one (1) year from the stated date below. I understand that I may see and copy the information described on this form if I ask for it. I specifically authorize and permit discussion with and obtaining of opinions of all treating and examining physicians. A photocopy of this authorization will be treated in the same manner as the original.

Signature of Patient or Personal Representative

Printed name of Patient or Personal Representative

Date

Relationship of Personal Representative to Individual