Falmouth Orthopaedic Center

Authorization for Release of Health Information

I,______________________________DOB_____________(Maiden Name______________)
Patient Name

Authorize: To Disclose to:

Authorize:	To Disclose to:
Falmouth Orthopaedic Center	Name:____________________________________
20 Northbrook Drive	Address:____________________________________
Falmouth, ME 04105	City:_________________State______Zip________

Any health information and records of any treatment or examination rendered to me for the following medical condition:____

Please circle Yes or No regarding permission to release the following types of information:

Yes/No Release Alcohol or Drug Dependency records
Yes/No Release Mental Health Treatment Records – Specific Diagnosis
Yes/No Release HIV/AIDS Antibody Test Results and Diagnosis/Treatment Records

-I understand that once this information is released, my physician and/or his employees cannot prevent the re-disclosure of that information. I release Falmouth Orthopaedic Center and any of it's employees from any and all liability arising directly from disclosure authorized by this consent and any re-disclosure of that information.
-I understand that I have the right to revoke this authorization at any time. Authorization will be considered inactive when Falmouth Orthopaedic Center receives a request in writing to revoke authorization.

This authorization for disclosure is effective for one year from the date signed.

_____________________________________ _____________________
Signature of Patient Date

_____________________________________ _____________________
Signature of Legal Representative Date

Authority to Act – Legal Representative:

- ❑ Legal Guardian
- ❑ Executor of Estate
- ❑ Spouse of Deceased
- ❑ Health Care Power of Attorney

Updated 10/2006/foc