MEIER ORTHOPEDIC
SPORTS MEDICINE

Phone: 1.310.777.7845
Fax: 1.310.247.0342

Authorization To Release Medical Information and/or Disclosure of Medical Information

(*Treatment, payment, enrollment or eligibility for benefits will not be conditioned on my providing or refusing to provide authorization.)*

Request Medical Information From: _____

Phone Number: _____ Fax_____

Please Send Medical Information To:
Name: Meier Orthopedic Sports Medicine
Attention: Steven W Meier, M.D. **Phone:** (310) 777-7845 **Fax:** (310) 247-0342

I, _____, hereby authorize the release and or disclosure of the medical information as indicated below to: **Meier Orthopedic Sports Medicine, Steven W. Meier, M.D.**

Release and/or disclose records and information regarding:

Name: _____ Date of birth_____

Address: _____

Phone Number: _____

Duration: This authorization shall become effective immediately and shall remain in effect for 1 year from the date of signature.

Revocation: This authorization may be revoked in writing by the undersigned at any time prior to the release of the information from the disclosing party. Written revocation will not affect any action taken in reliance on this authorization before written revocation was received.

Re-disclosure: I understand that the requester may not lawfully further use or disclose the health information unless another authorization is obtained from me or unless disclosure is specifically required or permitted by law.

Records to be released: *All reports of diagnosis, treatment, prognosis and recommendations, X-Rays, MRIs, CT scans, or any other radiological exams or reports, as well as other data pertinent to the treatment rendered to me within your facility from* _____ *to present.*
(specified date)

Date: _____ / _____ / _____ Signature: _____