

St. Peters  
**Bone & Joint**  
Surgery

GENERAL ORTHOPEDICS • SPINE • SPORTS MEDICINE  
FOOT & ANKLE SURGERY • JOINT REPLACEMENT • HAND SURGERY

Thomas E. Albus, M.D.  
W. Anthony Frisella, M.D.  
Timothy G. Graven, D.O.  
Richard B. Helfrey, D.O.  
Brandon D. Larkin, M.D.  
John W. McAllister, M.D.  
Theodore S. Rummel, D.O.  
Paul M. Spezia, D.O.  
Marie Freise, PA-C  
Jeffery Wallace, PA-C

**AUTHORIZATION FOR RELEASE OF MEDICAL RECORDS (PHI)**

**Instructions:**

*All blank spaces must be filled and boxes checked. Any blank spaces and/or boxes that have not been completed will render this Authorization incomplete and, therefore, defective. Defective Authorization forms will be returned to you and no records will be released.*

This request for disclosure of medical information is made at my request for the purpose of

\_\_\_\_\_

I authorize \_\_\_\_\_ to:

- |  |   |
|--|---|
| <input type="checkbox"/> Release Medical Records | <input type="checkbox"/> Obtain Medical Records |
| <input type="checkbox"/> Release Billing Records |   |
| <input type="checkbox"/> Release Films or CDs    |   |

Specific information to be released: \_\_\_\_\_.

Dates of service: from \_\_\_\_\_ to \_\_\_\_\_.

Patient's full name \_\_\_\_\_  
Last First Middle Initial

Date of birth \_\_\_\_\_ Social Security Number \_\_\_\_\_

Patient address \_\_\_\_\_  
Street Address

City State Zip code

Patient home phone \_\_\_\_\_ Cell phone \_\_\_\_\_

**TO / FROM** \_\_\_\_\_  
Name of physician / facility / agency

Street Address

City State Zip code

Telephone number Fax number

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I understand that this authorization will expire one (1) year from the date signed.

I understand that I may revoke this Authorization at any time by notifying the providing organization in writing, except to the extent the organization has taken action in reliance on the consent.

I understand that if the organization authorized to receive the information is not a health plan or healthcare provider covered by federal privacy regulations, the release of such information may no longer be protected by federal privacy regulations.

I understand that I am under no obligation to sign this form and that the person(s) and/or organization(s) described above to whom I am authorizing to use and/or disclose my health information may not condition treatment, payment, enrollment in a health plan or eligibility for healthcare benefits on my decision to sign this Authorization.

I permit the release of all information indicated above, including, if any, all information concerning drug/alcohol treatment or use, AIDS/HIV or other communicable diseases, mental and behavioral health or sexually transmitted diseases.

\_\_\_\_\_  
Signature of Patient

\_\_\_\_\_  
Date

.....  
Patient is unable to sign because: \_\_\_\_\_

Name of personal representative \_\_\_\_\_

Relationship to patient \_\_\_\_\_

Street address \_\_\_\_\_

City, State Zip \_\_\_\_\_

Telephone number \_\_\_\_\_

Cell phone number \_\_\_\_\_

Authority of Personal Representative \_\_\_\_\_

*(e.g. healthcare power of attorney, guardian, other statutory authorization, must provide legal documentation)*

\_\_\_\_\_  
Signature of Personal Representative

\_\_\_\_\_  
Date