COLUMBIA ORTHOPAEDIC GROUP

1 South Keene Street • Columbia Missouri 65201 • 573-443-2402

CONSENT AND REQUEST FOR RELEASE OF MEDICAL RECORDS

The Columbia Orthopaedic Group is hereby authorized to disclose and release the medical records and related sensitive information in its possession concerning:

_____ _____ _____

Patients' name | Patient's SSN | Patient's Date of Birth

This authorization permits the Columbia Orthopaedic Group to disclose the following. (*Please describe the information to be disclosed.*) _____

_____

This information may be released to: (*Please provide the name and address of the person to receive these records.*)

_____

_____

Purpose of the disclosure: _____.
If requested by the patient, purpose may be listed as "at the request of the individual." This authorization will expire on _____.
Expiration Date or Defined Event

I hereby generally release and hold harmless the Columbia Orthopaedic Group (and all affiliated physicians) from all claims for damages or injury directly or indirectly caused as a result of disclosing said medical information or records to the above named authorized recipients(s). Revocation of this release must be in writing and may not be applied retroactively.

_____ _____

Signature of Patient (if a minor see below) | Witness

_____ _____

Date | Date

Authorization for Minor or Incapacitated Patient

This portion of this form must be completed by someone who is acting on behalf of the patient in completing this form and in granting the authority hereafter described. If you are signing this form for someone else who has been treated by the Columbia Orthopaedic Group, you must have the authority to act on their behalf. By signing this portion of the form, you are representing and warranting to the Columbia Orthopaedic Group that you are authorized to act for the patient as that patient's parent or lawful guardian (if the patient is a minor) or as the guardian of the patient (if the patient is incapacitated).

I certify that I have the authority to execute this form on behalf of the person mentioned above:

_____ _____

Signature of Patient (if a minor see below) | Witness

_____ _____

Date | Date