HVMG ORTHOPEDICS

Carolyn P Engle, MD
Andrew S Kaye, MD
John D Lehman, MD
Alexis E Pilato, MD
S Dale Yakish, MD

HVMG Orthopedics
Authorization for Release of Protected Medical Information

Patient Name (PRINT)_____

Social Security#_____**Birthdate**_____

I hereby authorize HVMG Orthopedics to provide:

Name_____

Address_____

_____

Entire Record_____**Other**_____

_____

Purpose of disclosure: (Check one)

----My personal use
___Continued care
___Other (Describe)_____

HIV, Behavioral Health, and Drug & Alcohol information contained in the records indicated above will be released through this authorization unless otherwise indicated.
Do Not Release: _____HIV _____Behavorial Health (Psychiatric) _____Drug & Alchohol

_____ _____
Signature **Date**

_____ _____
Signature of Parent/Guardian) **Date**

This authorization for release of information is valid for six months from the date of signature, unless a sooner expiration date/event is noted above, or unless the authorization is revoked by written notice.

NOTE: THERE MAY BE A CHARGE FOR RECORD COPYING

Beaver Medical Commons
1030 Beaner Hollow Road • Beaver, PA 15009 • 724-775-4242 • Fax 724-775-4960