Baton Rouge Orthopaedic Clinic

Authorization for Release of Medical Records Must be Completed

I hereby authorize Baton Rouge Orthopaedic Clinic to use or disclose the following protected health information (PHI) from the medical records of the patient listed below to:

Requested By: Address:		
Patient Name: Patient DOB:		
D .: . CON		
D .: 1.1		
Disclose the following PHI f		
History & Physical	Progress Notes	Consult
Physician Orders	X-Ray Report	Nurses Notes
Chart Notes	Other Specify	MRI Results* *If Applicable
	egalInsuranceF ereby consent to such, th	PersonalOther at the released information may
	F-7	
This authorization shall expire u ***If a specified date is not ent form is signed.	pon this expiration date:ered the authorization will ex	xpire in six (6) months from the date
 to BROC. I understand the released pursuant to the automation used or definition to the recipient and no longer 	nat this revocation will not app athorization. lisclosed pursuant to the authori r protected.	ion at any time and must do so in writing by to information that has already been zation may be subject to redisclosure by efits may not be conditioned on signing
this authorization.	anominent of englotting for bell	chis may not be conditioned on signing
	thorize the disclosure of the	ne protected health information as
Signature of Patient/Legal Gu	ıardian	Date
Witness		Date