Proximal®

CONSIGLIO WELLNESS CENTER

RELEASE OF INFORMATION

Last Name:_____ First Name:_____

Date of Birth:_____ SSN:_____

Address: _____ Phone: _____

Patient authorizes:

Facility: Orthopedic & Sports Medicine Center

Address: 3107 Frederick Avenue, Suite B, St. Joseph, MO 64506

Phone: (816) 233-9888 Fax: (816) 233-0414 Attention: Billing/PAR Team

TO / FROM: ☑ **Release** ☐ **Obtain** Health Information

TO / FROM: ☐ **Self** ☐ **Physician** ☐ **Facility** ☑ **Other:** Benefit Plan

Name / Organization: School District Employee Benefit Plan/Proximal Attention: _____

Address: PO Box 178 City: Crystal Bay State: MN Zip:55323

Phone: 816-874-3379 Fax: 1-844-903-4574

☐ Complete Medical Records	☐ Operative Reports	☐ Medication Lists	☐ Hospital Reports
☑ Complete Billing Records	☐ Radiology Reports	☐ Work Status Notes	☐ Orders
☐ Progress Notes	☐ Radiology Images	☐ Lab Reports	☐ Other:_____

Dates Requested: ☑ Any dates before/after date of signature **Or** ☐ Date Range: _____

Purpose of Request: Administration of Supplemental Benefit

Notes: HCFA Form(s)

The information about you is protected under federal law and you have the right to revoke this authorization in writing. Please be advised that any revocation will be effective only to the extent we have not already taken action in reliance on your authorization. By signing below, you recognize that the protected health information used or disclosed pursuant to this authorization may be subject to re-disclosure by the recipient of this disclosure and may no longer be protected under federal law. We will not condition treatment based on your authorization. This authorization expires on the following date:_____ If left blank, I agree this authorization shall be valid for a period of twelve (12) months from today's date. All patients requesting medical records are required to show current identification for signature verification for the release of medical records.

Signatures

Patient Signature:_____ Date of Birth:_____

Printed Name:_____ Today's Date:_____