COMMONWEALTH ORTHOPAEDIC ASSOCIATES
A division of Keystone Orthopaedic Specialists, LLC

AUTHORIZATION FOR RELEASE OF MEDICAL INFORMATION FOR THE PURPOSE OF COMPLETING DISABILITY FORMS

Patient Name:_____ Date of birth:_____

I authorize a representative from **Commonwealth Orthopaedic Associates** to disclose the above-named individual's health information as directed below, for the purpose of completing a disability form:

INFORMATION RELEASED TO: _____
Name of Company/ Agency/ Facility/ Person

_____
Complete Street Address

_____
City, State, Zip Code

INFORMATION TO BE RELEASED:
☑ **Records requested by the company listed above, for the purpose of disability determination.**

I hereby authorize disclosure of the health information for the above named patient. The information being disclosed may include HIV/AIDS, Drug/Alcohol Abuse & Mental Health data. This document authorizes release of information entered in my medical record prior to or within 12 months after the date of my signature. I understand that I may cancel this request with written notification but that it will not affect any information released prior to notification of cancellation. I understand that the information used or disclosed may be subject to re-disclosure by the person or class of persons or facility receiving it, and would then no longer be protected by federal regulations.

_____ _____
Signature of patient / legal guardian or Personal Representative of patient's estate **Date**