Authorization to Release Request

We are pleased to be assisting you with your medical forms. Be advised there can be up to a 10-business day processing time frame, as well as a processing fee based on the type of form.

We understand you may have an urgent deadline for your paperwork and will do our best to accommodate; however, all paperwork will be processed in the order that we receive it without exception. If you would like a copy of the form for yourself, please contact Klamath Orthopedic Clinic directly.

By law, we are required to have you provide us with a signed authorization giving your permission to disclose your information. By completing the form below, you are authorizing disclosure of your private health information.

***Indicates Required Field**

***Patient's Name** *(First, Middle Initial, Last)* _____

***Date of Birth** _____ ***Preferred Daytime Phone Number** _____

OK to Leave a Detailed Phone Message? □ **Yes** □ **No** ***E-Mail Address** _____
**Email address will be used to provide status updates*

***Payment* - □ Form Fee $25**

Date of Symptoms Onset: _____ **First Day Unable To Work**: _____
Length of expected leave: _____

***Name of company or employer to receive form:**

Complete additional copy of this form for each form requested.

Name: _____
Address: _____
_____
Fax: _____

*****Attach this form to the document to be completed for disability determination**

I authorize Klamath Orthopedic Clinic to provide charts, notes, x-rays, operative reports, lab and medication records, and all other medical information about me, including medical history, diagnosis, testing, test results, prognosis, and treatment of any physical or mental condition, including any disorder of the immune system, including HIV, AIDS or other related syndromes or complexes; any communicable disease or disorder; any psychiatric or psychological condition, including test results; any condition, treatment, or therapy related to substance abuse, including alcohol and drugs; and any non-medical information requested about me, including things such as education, employment history, earnings or finances, return to work accommodation discussions or evaluations and eligibility for other benefits or leave periods including but not limited to claims status, benefit amount, payments, settlement terms, effective and termination dates, plan or program contributions.

I also acknowledge I am responsible for paying the form completion fee before form completion.

Signature: _____ Date: _____ Last 4 digits of your SS# _____
Full name

□ I electronically sign this document and agree to the terms and conditions and that the information is accurate. Further, I verify my identity through this electronic signature.

****FOR OFFICE USE ONLY****

□ **Signed Release on File**

□ **I approve this form completion** _____ **Provider/Designee Signature**