



**Orthopedic & Sports Medicine Specialists (OSMS)**  
**Authorization for Release of Patient Identifiable Health Information**

**Patient Name:** \_\_\_\_\_

**Patient DOB:** \_\_\_\_\_ **Patient ID:** \_\_\_\_\_

I authorize the use or disclosure of the above named individuals health information as described below. I understand that I have the right to refuse to sign this authorization. OSMS is authorized to send and to receive the records.

**Name Address, Fax & Phone number for individual who is authorized to SEND the records.**

OSMS - 2223 Lime Kiln Rd Ste. 1 Green Bay, WI. 54311 – PH:920.430.8113 FAX: 920.430.8122

**Name, Address, Fax & Phone number for individual or organization authorized to RECEIVE the records:**

\_\_\_\_\_

**Information that may be released** (check all that apply):

- ☐ Office Notes      ☐ Operative Reports      ☐ Therapy/Test Results      ☐ Radiology CD/Report  
☐ Any Disability/FMLA Information  
☐ Information relating to mental health, alcohol or drug abuse or developmental disability  
☐ HIV test results (according to Wis. Stat. 252.15 I have the right to request a list of releases made of my HIV test results without my consent),

**Specify body part of the records to be released (if any)** \_\_\_\_\_

**Specific dates/date range you would like released:** \_\_\_\_\_

**X** \_\_\_\_\_

Signature of Patient or Personal Representative, person authorized  
relationship, legal authority by patient or other legal authority

**X** \_\_\_\_\_

Date

**Record Retrieval Options:**

- ☐ Pick up:      ☐ Fox Valley      ☐ Green Bay      ☐ Marinette  
☐ E-Mail: Address \_\_\_\_\_  
☐ Mail to the address above.

**This authorization is to remain in effect for one year or unless otherwise noted:** \_\_\_\_\_

**Right to inspect or copy the information to be used or disclosed:** I understand that I have the right to inspect or copy the information used or disclosed in the authorization. I can contact OSMS Privacy Officer.

**Right to receive a copy of this authorization:** I understand that if I agree to sign this authorization, which I am not required to do, I will receive a copy of this signed authorization.

**Redisclosure of information by recipient:** I understand that any disclosure of information carries with it the potential for an unauthorized redisclosure and the information may not be protected by confidentiality rules. If I have questions about the disclosure of my health information, I can contact OSMS Privacy Officer at 2223 Lime Kiln Rd Green Bay WI 54311 or 920.430.8113.

**Prohibition of Conditions:** OSMS may not condition treatment, payment, enrollment in a health plan, or eligibility for benefits based on the provision that I authorize this disclosure of my protected health information.

**Right to Revoke Authorization:** I understand that I have the right to revoke this authorization at any time. I understand that if I revoke this authorization I must provide the revocation in writing to OSMS. I understand that the revocation will not apply to information that has already been released in response to this authorization. I understand that the revocation will not apply to my insurance company when the law provides my insurer with the right to contest a claim under my policy.

I understand that if OSMS uses this authorization for marketing activities, I will be informed if they receive any direct or indirect remuneration related to the use or disclosure of my protected health information.