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Physical Therapy



# Cincinnati SportsMedicine and Orthopaedic Center

## Authorization for Release of Medical Information

Patient's name: _____	Date of Birth: _____
Address: _____	
City/State/Zip Code: _____	
SS#: _____	Patient's phone #: ( ) _____
Date of Request: _____	Date Needed: _____

<b>OR</b>	
<input type="checkbox"/> I authorize the Cincinnati SportsMedicine & Orthopaedic Center to release information to: Name of Provider or Facility _____ Address _____ City, State, Zip Code _____ Phone #/Fax # (include area code) _____	<input type="checkbox"/> I authorize the Cincinnati SportsMedicine & Orthopaedic Center to obtain information from: Name of Provider or Facility _____ Address _____ City, State, Zip Code _____ Phone #/Fax # (include area code) _____

**PURPOSE FOR THIS REQUEST:** (Check one.)  Healthcare  Insurance coverage  Personal  Other  
 Transfer of Care

**TYPE OF RECORDS REQUESTED:** (Check one.)

All medical records related to a specific illness or injury.

Specify illness/injury \_\_\_\_\_

Date(s) of treatment \_\_\_\_\_

Specific information (Select one or more, as applicable)

Procedure report

History & physical

Physical Therapy

Laboratory test results

Operative reports

X-ray reports

(Please describe.) \_\_\_\_\_

Entire copy of the record checked above.

**AUTHORIZATION VALID FOR:** (Check one.)

This request only.

One year from the date of this authorization **OR** \_\_\_\_\_. (Insert date.) This authorization applies to the records of the treatment received on or prior to the date of this authorization.

This request **and** for medical records of any **future** treatment of the type described above until: \_\_\_\_\_  
Insert Date

**I understand that:**

- My right to healthcare treatment is not conditioned on this authorization.
- I may cancel this authorization at any time by submitting a written request to the address provided at the top of this form, except where a disclosure has already been made in reliance on my prior authorization.
- If the person or facility receiving this information is not a health care or medical insurance provider covered by privacy regulations, the information stated above could be redisclosed.
- There may be a charge for the requested records.

**NOTE: Medical records are faxed in cases of medical necessity only.**

Signature of Patient or Representative \_\_\_\_\_ Date \_\_\_\_\_

Relationship to Patient (if requester is not the patient) \_\_\_\_\_

Witness Signature \_\_\_\_\_ Date \_\_\_\_\_

Witness Name \_\_\_\_\_

Montgomery  
10663 Montgomery Road  
513-891-3200  
513-792-3239 Fax

Tri-County  
12115 Sheraton Lane  
513-671-0311  
513-346-7299 Fax

Western Hills  
3301 Westbourne Drive  
513-347-9999  
513-347-3999 Fax

Mason  
9311 Mason-Montgomery Road  
513-573-0006  
513-573-9178 Fax

Northern Kentucky  
328 Thomas More Parkway  
859-331-9700  
859-344-4153 Fax