



## AUTHORIZATION TO OBTAIN INFORMATION

**Carrier Name:** \_\_\_\_\_

I authorize St. Croix Orthopaedics, P.A. (SCO) to release information relating to the diagnosis, treatment, and prognosis of any physical condition and/or treatment of the insured for which a disability claim is being made.

I **UNDERSTAND** that SCO will provide the information to the disability carrier named above, so that processing of the claim can continue in a timely manner.

I **KNOW** that I may request a copy of this Authorization.

I **AGREE** that a photo static copy of this Authorization shall be considered as valid as the original.

I **AGREE** that this authorization shall be valid as long as the resolution of the claim is pending.

This authorization must be signed and dated and may be revoked at any time according to St. Croix Orthopaedics, P.A. Notice of Privacy Practice except to the extent action has been taken prior to revocation. This consent will expire 365 days after the date below or sooner by my choice, in which case this consent will expire on \_\_\_\_\_. I hereby state that I have read and fully understand the above statements as they apply to me. I hereby consent to the disclosure of the medical records to the purpose and extent stated above. Once these records are released, this information is not protected by St. Croix Orthopaedics, P.A. and may potentially be redisclosed by the party who received these records. I release St. Croix Orthopaedics, P.A., its employees, agents, directors, officers and affiliates from any liability that may be incurred by giving this information to the above. **The undersigned acknowledges that there may be a charge for retrieval and copies of medical records and/or x-rays.**

**Claimant's Name** (please print): \_\_\_\_\_

\_\_\_\_\_  
**Claimant's Signature**

\_\_\_\_\_  
**Date of Birth**

\_\_\_\_\_  
**Date of Signature**