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BETTER EXPERIENCE. BETTER RESULTS.

MEDICAL RECORDS RELEASE

Patient's Full Name: \_\_\_\_\_ DOB: \_\_\_\_\_ Phone #: \_\_\_\_\_

Patient's Former Name (if applicable): \_\_\_\_\_

PATIENT AUTHORIZES ORTHOPAEDIC SPECIALISTS TO (COMPLETE ONE BOX):

OBTAIN RECORDS FROM: Name \_\_\_\_\_ Address \_\_\_\_\_ City/State/Zip \_\_\_\_\_ Phone \_\_\_\_\_ Fax \_\_\_\_\_

RELEASE RECORDS TO: Name \_\_\_\_\_ Address \_\_\_\_\_ City/State/Zip \_\_\_\_\_ Phone \_\_\_\_\_ Fax \_\_\_\_\_

PURPOSE OF DISCLOSURE

- Continuing Care Insurance Legal Personal Use Transfer of Care Other (Please specify):

RECORDS TO INCLUDE:

- Paper records to include (Choose 1 from options below): Entire chart Specific body part Date Range X-Ray Disc (outside imaging exams must be obtained from the performing facility)

DISCLOSURE OF SENSITIVE INFORMATION

I understand that my health record may contain sensitive information relating to my condition(s). This includes, but is not limited to, information pertaining to sexually transmitted disease, human immunodeficiency virus (HIV), acquired immunodeficiency syndrome (AIDS), behavioral or mental health services, and treatment for alcohol and drug abuse.

By checking here, I choose to exclude the above types of information from this disclosure. [ ]

TERMS AND CONDITIONS

- I have the right to revoke this Authorization, in writing, at any time by notifying the administration at Orthopaedic Specialists, P.C., and the health care provider being requested to disclose health information (if applicable). Such revocation will not apply to information that already had been disclosed in reliance of this Authorization. I have the right to not sign this Authorization. Orthopaedic Specialists, P.C., will not condition treatments, payment for services or enrollment, or eligibility for benefits on whether I sign this Authorization. If health information is disclosed to a person who is not covered by federal or state confidentiality laws, there is the potential for this information to be subject to re-disclosure and no longer be protected by these laws. I have read and understand this Authorization, have had an opportunity to have my questions answered, have signed this Authorization freely, and have received a copy of this Authorization, if desired. Please note, this authorization expires (1) year after the date of signature unless otherwise specified: \_\_\_\_\_

SIGNATURE: \_\_\_\_\_ DATE: \_\_\_\_\_

PRINT NAME: \_\_\_\_\_ SIGNED BY: [ ] Patient [ ] Parent [ ] Legal Representative