

## AUTHORIZATION FOR PROTECTED HEALTH INFORMATION

Patient Name \_\_\_\_\_ Date of Birth \_\_\_\_\_

Address \_\_\_\_\_ City \_\_\_\_\_ State \_\_\_\_\_ Zip \_\_\_\_\_

Social Security Number \_\_\_\_\_ Phone \_\_\_\_\_

I HEREBY AUTHORIZE Advanced Orthopaedics & Rehabilitation TO:      RELEASE TO      OR      OBTAIN FROM

Name of Doctor/Hospital/Facility \_\_\_\_\_

Address \_\_\_\_\_ City \_\_\_\_\_ State \_\_\_\_\_ Zip \_\_\_\_\_

Fax Number \_\_\_\_\_

Records are requested for the purpose of continuation of medical treatment, payment of bill, workman's comp, other education, self, legal or insurances purposes **PLEASE PROVIDE DETAILED DESCRIPTION** \_\_\_\_\_

(Records will not be released if this is left blank)

### Information to be Disclosed

<u>Hospitalizations</u>	<u>Dates</u>	<u>Outpatient Visits</u>	<u>Dates</u>	<u>Other</u>	<u>Dates</u>
Discharge Summary _____		Progress Notes _____		Complete Health Record _____	
History & Physical _____		Diagnosis _____		Electronic Health Information (USB) _____	
Laboratory _____		Laboratory _____		Other, specify: _____	
Consultation _____		Radiology Reports _____		X-Ray Films/CD _____	
Operative Report _____		Itemized Bills _____		Body Part _____	

Advanced Orthopaedics & Rehabilitation requires \$5.00 charge for a digital copy(CD) of all x-ray images. A \$20.00 deposit is required for the release of actual films. Since actual films are a permanent part of your medical record, films must be returned within 30 days, and the \$20.00 deposit will be returned by check.  
 A \$10.00 charge is required for all information requested on a USB drive.

- This authorization will expire one year from the date of your last signature below, unless you specify an earlier termination. You must renew or submit a new authorization after the expiration date to continue the authorization. Please list the date of expiration if earlier than one year \_\_\_\_\_
- You have the right to terminate this authorization at any time by submitting a written request to our Privacy Manager. Termination of this authorization will be effective upon written notice, except where a disclosure has already been made based on prior authorization.
- The practice places no condition to sign this authorization on the delivery of healthcare or treatment.
- We have no control over the person(s) you have listed to receive your protected health information. Therefore, your protected health information disclosed under this authorization may no longer be protected by the requirements of the Privacy Rule, and will no longer be the responsibility of the practice.

You have the right to receive a copy of signed authorizations upon request.

**FOR OFFICE USE ONLY**

Fees	Paid
CD \$5.00 _____	
EHI \$10.00 _____	
Films \$20.00 _____	

When Films are Returned,  
 Print from SRS and give to Billing

Date Returned \_\_\_\_\_

Staff Signature \_\_\_\_\_

Patient Signature \_\_\_\_\_

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

\_\_\_\_\_  
 Signature of Parent, Legal Guardian or Legal Representative      Date

\_\_\_\_\_  
 Signature of Witness/Staff Member      Date