BONE AND JOINT INSTITUTE

Authorization for the Release of Medical Records

WHERE ARE THE RECORDS COMING FROM?

Facility/Doctor's Name: _____

TELL US ABOUT THE PATIENT.

Name: _____ DOB: _____ SSN: xxx-xx-_____

Email: _____ Phone #: _____

Address: _____

City: _____ State: _____ Zip: _____

WHERE ARE WE GETTING THE RECORDS FROM?

Name: _____

Email: _____

Address: _____

City: _____ State: _____ Zip: _____

Phone #: _____ Fax #: _____

WHAT WOULD YOU LIKE RELEASED?

- ☐ All Records
- ☐ Office/Clinic Notes
- ☐ Operative Reports
- ☐ Lab/Pathology Results
- ☐ Radiology Reports
- ☐ Immunization Records
- ☐ Dates _____ to _____
- ☐ Other _____

PURPOSE OF DISCLOSURE: WHY ARE WE SENDING THE RECORDS?

- ☐ Personal Use
- ☐ Litigation/Legal
- ☐ Continuation of Care
- ☐ Insurance

DELIVERY METHOD: HOW WOULD YOU LIKE THE RECORDS SENT?

- ☐ Email
- ☐ Fax
- ☐ Pick-up in Office

PATIENT'S SIGNATURE:

I hereby authorize the use or disclosure of my health information as described below. I understand the information disclosed, pursuant to this authorization, may be subject to re-disclosure by the recipient and no longer protected by federal privacy regulations. I understand I have the right to refuse to sign this form and my refusal will not result in the physician conditioning the provision of healthcare with two exceptions: 1. Refusal to sign this authorization, if it is for disclosure of information created for research that includes treatment, may result in the physician declining to provide the research-related treatment. 2. Refusal to sign this authorization, if it is for disclosure of information created for the sole purpose of disclosure to a third party, may result in the physician declining to provide the healthcare which is for the sole purpose of creating protected health information for disclosure to a third party.

I understand I may revoke this authorization at any time by sending a written notice to Bone and Joint Institute. However, the revocation will not have any effect on any uses or disclosures Bone and Joint Institute may have made before the revocation was received. I understand unless I revoke the authorization earlier, this authorization will automatically expire six calendar months after the date this authorization is signed. I understand I may refuse to sign this authorization and Bone and Joint Institute will not condition treatment on whether I sign this authorization. The healthcare provider requesting the authorization will not receive financial or in-kind compensation in exchange for using or disclosing the health information described above.

I certify that I am:

- ☐ The patient and the identification I provided is true and correct.
- ☐ The patient's authorized representative, and the identification and proof of authority I have provided are true and correct.

  My relationship to the patient is that of: _____

Signature: _____ Date: _____

Printed Name: _____