Authorization to Disclose (Release) Protected Health Information (PHI)

orthopedic ONE

Patient Name: _____ **Date of Birth**:_____

First Middle Last

Address: _____

Street City State Zip

Phone Number: _____ **Dates of Service:**_____

Method of Release (Please check the appropriate box)

☐ To be Picked up by ☐patient ☐Other_____
Date Needed: _____

☐ To be mailed to physician or organization listed below

☐ To be mailed to the patient

☐ To be faxed to physician or organization listed below

Purpose of Release:

☐ Physician appointment (no charge)

☐ Personal record keeping (no charge)

☐ Other_____ (there may be a charge)

Fees: According to Ohio Revised Code, there is a per page fee for records. This fee will be dependent on the number of copies requested and other reasons as specified in ORC 3701.741 at codes.ohio.gov/ORC.

Physician Practice/Organization Authorized to **Release** Information

Name: _____

Address: _____

City, State & Zip: _____

Fax # _____ Phone #: _____

Physician Practice/Organization Authorized to **Receive** Information

Name: _____

Address: _____

City, State & Zip: _____

Fax # _____ Phone #: _____

Information to be Released: Check the type and amount of information to be used or disclosed is as follows:

☐ Progress Notes
☐ Operative report
☐ Lab reports
☐ MRI and X-ray reports
☐ MRI and X-ray images/CD
☐ Physical Therapy notes
☐ Entire Record
☐ Other_____

Expiration: This authorization for release of protected health information for the date(s) of service indicated is effective until _____or for a maximum of one year from the date signed below.

Revocation: I understand I have the right to revoke this authorization in writing at any time and present my written revocation to Orthopedic One. I understand the revocation will not apply to information that has already been released in response to this authorization. I understand the revocation will not apply to my insurance company when the law provides my insurer with the right to contest a claim under my policy.

Disclosure: I understand that authorizing the disclosure of this health information is voluntary. I can refuse to sign this authorization. I need not sign this order to assure treatment. I understand I may inspect or copy the information to be used or disclosed as provided in CFR 164.524. I understand any disclosure of information carries with it the potential for an unauthorized re-disclosure and the information may not be protected by federal confidentiality rules. I hereby authorize Orthopedic One to release the health information indicated above that is contained in my patient records to the Recipient named above. I understand and acknowledge that this may include information relating to sexually transmitted disease, acquired immunodeficiency syndrome (AIDS), or human immunodeficiency virus (HIV). It may also include information about behavioral or mental health services, and treatment for alcohol and drug abuse.

_____ _____

Signature of Patient or Legal Representative **Date**

_____ _____ _____

Legal Representative **Relationship to Patient** **Date**

*If signed by Patient's Legal Representative, and not previously provided, please include a copy of the document authorizing your authority to act on behalf of the patient (e.g. health care power of attorney).

Office Use: ☐ ID Check Recipient: ☐patient ☐Other_____ (must match above) Staff Initial _____ Date _____