

Account # _____



Doctor _____

Forms Medical Records

Employee Initials: _____

A Division of The Orthopedic Institute of Pennsylvania

AUTHORIZATION FOR RELEASE OF INFORMATION

I hereby authorize the use or disclosure of my individually identifiable health information as described below. I understand this authorization is voluntary. I understand that if the organization authorized to receive the information is not a health plan or health care provider, the release information may no longer be protected by federal privacy regulations, and that it may be re-disclosed by the recipient.

Patient Name: _____ Date of Birth _____

Information to be Disclosed: Complete Medical Record _____ Other _____

Purpose of Disclosure: _____ Patient Access _____ Disability/Insurance _____ Other _____

Release the Information to: _____

Choose how this information will be released:

Mail to: _____ Fax to: _____

Pick up: _____ Form completion is \$10 per form. Paid: Yes _____ No _____

PLEASE ALLOW 7-10 BUSINESS DAYS FOR FORMS COMPLETION

To the extent any of the following information is contained in my records being released, I specifically authorize the release of such information for the purposes indicated below by initialing before each category:

Initials: _____ ♦ HIV/AIDS testing, test results, treatment and related information including high risk behavior documented

♦ Drug and/or Alcohol diagnosis, treatment, test results and reports and referral information

♦ Mental health treatment information, test results and reports including psychological and psychiatric studies, reports, evaluations and referral information and/or

Initials: _____

_____ ♦ Venereal Disease information or Genetic testing, test results, counseling, reports, treatment, and referral information.

You must read and initial the following statements:

Initials: _____ ♦ I understand this Authorization will expire 7 YEARS FROM THE DATE OF SIGNATURE or on the following event: Termination of the Physician/Patient Relationship.

Initials: _____ ♦ I understand that I may revoke this Authorization at any time by notifying Orthopedic Institute of Pennsylvania's Privacy Officer in writing, but if I do, it will not have any effect on any actions Arlington Orthopedics took before they received the revocation.

Signature of patient or Representative

Last Four Digits Patient SS#

Patient Phone # _____

Relationship to Patient

Date

You may refuse to sign this authorization. We cannot condition your treatment on your signing this Authorization.