

**AUTHORIZATION TO DISCLOSE PROTECTED HEALTH INFORMATION**

Patient Full Name:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Date: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Date of Birth: \_\_\_\_\_\_\_\_\_\_\_\_Referring Physician: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_Address: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**I HEREBY AUTHORIZE ARLINGTON ORTHOPEDIC ASSOCIATES TO DISCLOSE MY PROTECTED HEALTH INFORMATION TO:**

Person/Organization Name:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Address:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

City: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_State: \_\_\_\_\_\_\_\_\_\_\_\_\_ Zip Code: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Phone: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_Fax: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Email:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**SEND VIA:** [ ] **Email** [ ]  **Mail** [ ]  **Fax** [ ]  **Pick-up**

**WHAT INFORMATION CAN BE DISCLOSED:**

* All Health Information
* Office Notes [ ] All [ ] Date:\_\_\_\_\_\_\_\_ to \_\_\_\_\_\_\_\_\_\_
* Physician Orders
* Radiology Report:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ [ ] All [ ] Date/Image\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_
* MRI Report [ ] MRI/X-ray CD [ ] All [ ] Date/Image\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_
* Operative Reports
* Hospital Reports
* Other \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**REASON FOR DISCLOSURE:**

[ ] Treatment/Continuing Medical Care [ ] Personal Use [ ] Disability [ ] Billing or Claims [ ] Legal [ ] School [ ] Employment [ ] Other

**RELEASE OF RECORDS DIRECTLY TO PATIENT**: I understand that my medical record may contain reports, test results, and notes that only a physician can interpret. I understand and have been advised that I should contact my physician regarding the entries made in my medical records to prevent misunderstanding of the information contained in these entries. I will not hold Arlington Orthopedic Associates P.A. and its physicians liable for any misinterpretation of the information in my medical record as a result of not consulting my physician for the correct interpretation. Initial:\_\_\_\_\_\_\_\_

I have read this form and agree to the uses and disclosures of information as described. I agree that a photocopy of this authorization shall be as valid as the original. I understand that information disclosed pursuant to this authorization may be subject to re-disclosure by the recipient and may no longer be protected by the federal or state law. I do not have to sign this authorization to receive treatment. I also understand that I have the right to revoke this authorization at any time. I understand that if I revoke this authorization I must do so in writing and present my revocation to the Privacy Officer at Arlington Orthopedic Associates, PA. I understand that the revocation will not apply to information already released in response to this authorization. I understand that the revocation will not apply to my insurance company when the law provides my insurer with the rights to contest a claim under my policy. Unless otherwise revoked, this authorization expires one year from the date of this request or upon the following date: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_. Initial\_\_\_\_\_\_\_

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_/\_\_\_\_\_/\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Print Patient’s Name Date Telephone Number

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Signature of Patient or Legal Guardian Relationship to Patient (Legal Representation)