TRI-CITY ORTHOPAEDICS

Medical Records Release Authorization

Upon presentation of this authorization, you are requested to provide the records outlined below.

Patient Info: _____
Patient Name Phone/Email DOB

To: _____ **From:** _____
Person/Company/Facility Name Person/Company/Facility Name

_____ _____
Address Suite/Bldg/Number Address Suite/Bldg/Number

_____ _____
City State Zip Code City State Zip Code

_____ _____
Phone Fax Phone Fax

Dates of Service (Check <u>one</u> and complete dates of service if required):

☐ Please provide a complete copy of my file

☐ Please provide a complete copy of my file for dates of service from _____ through _____.

Method of Delivery: ☐ Mail a Paper / Hard Copy ☐ Email Digital Copy / Link to Digital Copy ☐ Fax (see above)

Records to be Released:

☐ History & Physical ☐ Consultation Report(s) ☐ ER Record(s) ☐ Operative Report(s) ☐ Lab/Pathology Report(s)
☐ Discharge Summary ☐ Radiology Report(s) ☐ Radiology Image(s) (CD) ☐ Itemized Billing

☐ Other: _____

Purpose for Disclosure:

☐ Disability ☐ Insurance ☐ Attorney ☐ Referring Physician ☐ Patient Request ☐ Other: _____

Please indicate your acceptance by checking the following boxes:

☐ I understand that I may revoke this authorization in writing at any time except to the extent that action has been taken in reliance upon this authorization (45 CFR § 164.508(c)(2)(i)).

☐ I understand that treatment or payment cannot be conditioned on my signing this authorization, except in certain circumstances such as for participation in research programs, or authorization of the release of testing results for pre-employment purposes (45 CFR § 164.508(c)(2)(ii)).

☐ I understand that my records are confidential and cannot be disclosed without my written authorization except when otherwise permitted by law. Information used or disclosed pursuant to this authorization may be subject to redisclosure by the recipient and no longer protected. I Understand that the specified information to be released may include, but is not limited to: history, diagnosis, and/or treatment of drug or alcohol abuse, mental illness, or communicable disease, including Human Immunodeficiency Virus (HIV) and Acquired Immune Deficiency Syndrome (AIDS) (45 CFR § 164.508(c)(2)(iii)).

This authorization will expire One Hundred Eighty (180) days from the date of my signature unless I revoke the authorization prior to that time.

_____
Date Printed Name of Patient or Legally Authorized Representative Signature of Patient or Legally Authorized Representative