Authorization To Release/Obtain Protected Health Information

Patient Name (please print): ____________________________________ **Patient Date of Birth:** _______________

I hereby authorize Shoreline Orthopaedics to: ☐ DISCLOSE and/or ☐ OBTAIN the following information contained in my medical record from (date) _________________ to (date) _________________.

Name of person/organization to whom disclosure is to be released/obtained from:

Name: ____ Address: _______________________________________

City/State/Zip: _____________________________________ Phone #: ________________ Fax #: _________________

Specific Information Authorized for Release:

☐ Progress Notes/Consults ☐ Operative Reports

☐ Radiology Reports, Body Part ________________ ☐ Radiology Films, Body Part ______________________

☐ Emergency Department Notes ☐ Laboratory Reports

☐ Other ____

1. I understand that my records are protected under Federal and State law and cannot be disclosed without my written consent unless otherwise provided by law.
2. I understand that this authorization extends to all medical records of other providers to the extent of the records specified above; this may include any information about substance abuse treatment, behavioral health services, communicable diseases and infectious disease, including sexually transmitted disease, HIV infection, acquired immunodeficiency related complex, venereal disease, hepatitis or tuberculosis. Initial Here: ____________
3. I understand that I have the right to revoke this authorization at any time. if already signed, by submitting a written notification to the Medical Records Department to the facility releasing this information. If not previously revoked, this authorization to use or disclose protected health information will expire TWELVE (12) months from the date of my signature, or as otherwise specified. Initial Here: _____________
4. I understand that my continued or future treatment by or payment to Shoreline Orthopaedics is not conditioned upon my providing or signing this authorization unless this authorization is provided for the purpose of providing data in connection with medical or clinic trial research.

____ ______________________
Signature of Patient or Patient's Personal Representative (with relationship to Patient) Date

____ ______________________
Patient Name (please print) Patient's Date of Birth

Office Use Only:

Received by Employee (initials): ___________________ Date: _______________

☐ Mailed ☐ Faxed ☐ Patient Picked Up Date: __________________________ Employee (initials): _____________