Shoreline Orthopaedics

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 _____ ☐ Laboratory Reports

☐ Radiology Films/Disc - SEE OTHER SIDE FOR DETAILS Initial Here:_____Paid_____

☐ 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): _____

If you are requesting a disc of any x-rays that were done **AT** Shoreline Orthopaedics, and we have not referred you to another office/physician, there will be a charge to process that request, as listed below:

$5.00/one disc for current x-rays

Additional charges:
$5.00 to retrieve old x-ray films, plus an additional $1.00 per film that needs to be digitized.
$5.00 “flat fee” for mailing - additional charges, at cost, for any special mailing (overnight, etc.)

Treating Physician: _____

Total Charge: _____

Total Paid: _____ Cash/Ck/CC _____
Initials

Charges Posted: _____

If you are asking us to **OBTAIN** records from another office/physician, and you want the radiology films/discs (or if we have requested that we have them prior to making you an appointment), **YOU** are responsible for contacting that office to follow their process for releasing radiology, as there may be charges, etc., that they will need fulfilled before releasing their films/x-rays.