Name:
Chart:
Age:
Date:

OrthoConnecticut
World-class care, close to home.

AUTHORIZATION FOR RELEASE OF HEALTH INFORMATION FORM

FORM NEEDS TO BE COMPLETELY FILLED OUT IN ORDER TO PROCESS

Revocation
Date Revoked: _____
Initials of Privacy Official:

Patient's Name (First, Middle, Last) | Date of Birth | Social Security No.

Patient's Address | City | State | Zip

Home Phone with Area Code | Cell Phone No. | E-mail Address

I would like to disclose the following records:

☐ Entire Written Record
(Does not include x-ray images or billing records)

OR

☐ Date span from _____ to _____
including the following types of records:

☐ Diagnostic Reports
☐ Medication & Treatment Records
☐ X-ray images on disc (pre-payment required)
☐ Physician's Office Notes
☐ Billing Records
☐ Other (Please describe below)

_____
_____
_____

I would like these records provided to:

☐ Myself (via mail or e-mail – to patient only)
☐ Provider's Office (via mail or Fax only)
☐ Attorney's Office (via mail only)
☐ Other: _____

Send these records via:

☐ USPS Mail to: _____
_____

☐ Fax to: _____

☐ E-mail to: _____

To disclose records to additional recipients list addresses here:

_____ _____
_____ _____
_____ _____
_____ _____

Name:
Chart:
Age:
Date:

Authorization Statements/Signatures:

I understand that once the above information is disclosed it may be re-disclosed by the recipient. At which point the HIPAA Privacy Rule may no longer protect the information.

I understand I have the right to revoke this authorization at any time. I understand that if I revoke this authorization, it must be done in writing and delivered in person by me to a licensed OrthoConnecticut staff member. I understand that revocation will not apply to information that has already been released in response to this authorization.

I understand that the Facility will not condition the provision of treatment or payment on the provision of this authorization.

I understand Medical Records can only be mailed to an outside office (i.e., Provider, Attorney) and can only be mailed or e-mailed to myself.

I understand there may be a charge of up to .65 per page plus postage for my records.

_____ _____

Signature of Patient of Personal Representative Date

_____

Print Name

_____

Personal Representative's Title or Relation to Patient

This Authorization for Release form is valid for up to 1 year from the signature date. If you would like to retract this authorization, please contact OrthoConnecticut, PC in writing.