AUTHORIZATION FOR THE USE/DISCLOSURE OF PROTECTED HEALTH INFORMATION

The undersigned authorizes EmergeOrtho to release health information as noted below :

PATIENT INFORMATION

Patient Full Name: _____ Date Of Birth:_____

Other Names?: _____ Medical Records Number (if known) _____

Patient Address: _____

City: _____ State: _____ Zip: _____ Phone #:_____

RELEASE INFORMATION TO *(THIS SECTION MUST BE COMPLETED)*

Name/Facility: _____ Attention: _____

Address: _____ Phone #: _____

City: _____ State: _____ Zip: _____ Fax #: _____

Email Address for record delivery: ***Please ensure email address is legible.***

You must provide a valid email address and name of your designated recipient if electronic delivery is chosen.

Purpose of Request: ☐Personal ☐Treatment ☐Legal ☐Insurance ☐Transfer of Care ☐Other: _____

INFORMATION TO BE RELEASED (THIS SECTION MUST BE COMPLETED)

Specify Dates of Service _____

If you fail to specify, 1 year of records will be provided.

☐ Office Notes ☐ Operative Notes ☐ Labs

☐ Diagnostic Reports ☐ Physical Therapy

OR

☐ Complete medical record **excluding** radiology images (X-ray, MRI, etc.)

☐ Radiology images ($10 on CD)

☐ Other (please specify):

Copy fee to obtain records.

Medical record copies will be provided for a fee as and where allowed under applicable federal regulations and state law.

I understand I will be responsible for the charges incurred in the release of my protected health information.

RecordQuest will be responsible for processing and delivery of record requests. (Customer Support Number: 1-888-300-7410)

AUTHORIZATION TO RELEASE PROTECTED HEALTH INFORMATION

I understand that the released information may include information relating to treatment for drug or alcohol abuse, sickle cell anemia, psychological or psychiatric impairments, sexual transmitted disease, acquired immunodeficiency syndrome (AIDS), and/or human immunodeficiency virus (HIV).

1. I may refuse to sign this authorization and that it is strictly voluntary
2. My treatment, payment, enrollment or eligibility for benefits may not be conditioned on signing this authorization
3. I may revoke this authorization at any time in writing, but if I do, it will not have any effect on any actions taken prior to receiving the revocation. Unless otherwise revoked, this authorization will expire in one year.
4. If the requestor or receiver is not a health plan or health care provider, the released information may no longer be protected by federal privacy regulations and may be disclosed.
5. I understand that I may see and obtain a copy of the information described on this form, for a reasonable copy fee, if I ask for it. I can request a copy of this form after I sign and date it.
6. EmergeOrtho, its officers, employees, and physicians are hereby released from any legal responsibility for disclosure of the above information to the extent indicated and authorized herein.

STOP **Please confirm that you have filled out this form in its entirety. This form MUST be completed before signing.**

I hereby authorize the use or disclosure of my individually identifiable health information as described above.

Printed Name _____ Relationship to Patient: ☐Self ☐Other _____

Signature* _____ Date _____

**For non-emanicpated minors under the age of 18 a parent or guardian must sign release form. If patient is unable to sign, a copy of the legal documentation for the patient's representative must be supplied with a copy of this form.*