INFORMED CONSENT FOR DISCLOSURE OF PATIENT HEALTH CARE INFORMATION

1. ____________________________________ ____________________ ______________________________
(Name) (Date of birth) (Maiden Name)

____________________________________ ____________________ __________ __________
(Street address) (City) (State) (Zip code)

____
(Telephone number)

2. RELEASE RECORDS FROM: 3. RELEASE RECORDS TO:

____ ____
____ ____
____ ____

3. INFORMATION TO BE RELEASED:

________ All Clinic Records ________ Lab Reports
________ X-Ray Reports ________ MRI Reports
________ Other (please specify)____

Any request for records concerning any visit or treatment done at any other facility other than Orthopedic & Spine Therapy have to be requested from that facility.

4. REASON FOR RELEASE:

________ Transfer of Care __________ Consultation __________ Out-of-town move
________ Personal use __________ Other (Please Specify) ____

5. This authorization will remain in effect until this request is processed unless you specify the authorization to be effective for a longer period of time.
(Specify Longer time period or "NONE") ____

6. I authorize release of my medical records in accordance with the specifications listed above. I understand written notification is necessary to cancel this request. I release Othopedic & Spine Therapy, their employees and agents from all legal responsibility or liability that may arise from the act I have authorized. I (we) understand that information about me (us) may be disclosed under this authorization to persons or organizations that are not subject to the Health Insurance Portability and Accountability Act (HIPAA) and that the information would then no longer be protected by HIPAA and any related regulations. I understand I do not have to sign this authorization in order to obtain health care benefits (treatment, payment or enrollment).

7. SIGNATURE OF PATIENT: ____ DATE: ____________________
If signed by person other than patient, state relationship and authority to do so.

RELATIONSHIP TO PATIENT: ____________________________ WITNESS: ____

ORTHOPEDIC & SPINE THERAPY RESERVES THE RIGHT TO CHARGE FOR THE COPYING OF MEDICAL RECORDS.
Medical Records sent out/picked up on ____________________________ by ______________________________