# ORTHOPEDIC & SPINE THERAPY

## INFORMED CONSENT FOR DISCLOSURE OF PATIENT HEALTH CARE INFORMATION

| ______________________ | ______________ | ______________________ |
|---|---|---|
| (Name) | (DOB) | (Maiden Name) |

| ______________________ | ______________ | _______ | _______ |
|---|---|---|---|
| (Street Address) | (City) | (State) | (Zip Code) |

| **RELEASE RECORDS FROM:** | **RELEASE RECORDS TO:** |
|---|---|
| ______________ | ______________ |
| ______________ | ______________ |
| ______________ | ______________ |

**INFORMATION TO BE RELEASED:**

All Clinic Records ______________ MRI Reports ______________

X-Ray Reports ______________ Other ______________

Lab Reports ______________

**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.*

**REASON FOR RELEASE:**

Transfer of Care ______________ Out-of-town Move ______________

Personal Use ______________ Other ______________

Consultation ______________

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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" ________________________________

I authorize the release of my medical records in accordance with the specifications listed above. I understand that written notification is necessary to cancel this request. I release Orthopedic & 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 (HIPPA) 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).

**SIGNATURE OF PATIENT:** ________________________________ **DATE:** ______________________

**If signed by a person other than the patient, state relationship and authority to do so.*

**RELATIONSHIP OF PATIENT:** ______________________ **WITNESS:** ________________________________

*ORTHOPEDIC & SPINE THERAPY RESERVES THE RIGHT TO CHARGE FOR THE COPYING OF MEDICAL RECORDS.*

Medical records sent out/picked up on ______________________ by ______________________