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 ☐ Lab Reports ☐ X-Ray Reports ☐ Other

**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 ☐ Consultation ☐ Personal Use ☐ Other

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 _____