

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 :** _____

_____ 2a. **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 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 (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 : _____

