ORTHOPEDIC PARTNERS

Medical Record Release of Information Authorization

WHO

Patient_____ DOB_____ SSN_____

(last 4 of SSN)

AKA or Maiden Name_____

Patient Address_____

City_____ State_____ Zip_____

Email_____ Phone_____

WHERE

Where you would like the records *FROM:*	Where you would like verbal / written information sent or discussed Please complete all fields—larger files will need a complete mailing address
Doctor or Facility	____Self ____Family Member ____Other
Name_____Orthopedic Partners_____	Name_____
Address_____82 New Park Avenue _____	Address_____
_____	_____
City_____North Franklin_____	City_____
State_____CT_____ Zip_____06254_____	State_____ Zip_____
Fax_____860-823-2949_____	Fax_____

WHAT

In order to receive the fastest services, please specify the information that is requested. Larger files will take longer to process and deliver. Reducing requests to the minimum necessary allows for us to provide the fastest turnaround times.

Dates of Service _____ to _____

Incident or Injury Date _____ specific care (e.g. left knee) _____

Specific Information_____

_____

WHY

Purpose of Disclosure—Please Select <u>All</u> that Apply

____ Granting permission to speak with the above person(s) / entity regarding Treatment (medical care) and/or billing

____ Send records only

_____ Send x-ray images only

LEGAL

REQUIREMENTS

You MUST agree or disagree to each of the following—please be advised that disagreeing to any of the following may result in portions of your medical file being withheld from the response.

Unless otherwise revoked, this authorization will expire from the date that it was originally signed:

(choose one) ____ expires in 6 months ____expires in 1 year

My evaluation, diagnosis and / or treatment relating to the conditions listed below may be released to the requestor identified above for the following type of records unless otherwise indicated

Agree____ Disagree____ - AIDS (Acquired Immunodeficiency Syndrome) or HIV (Human Immunodeficiency Virus) Infection

Agree____ Disagree____ - Psychiatric care and / or psychological assessment

Agree____ Disagree____ - Treatment for alcohol and / or drug abuse

Agree____ Disagree____ - Mental Health Treatment

Failure to complete this section will automatically imply a declination of the above

SIGNATURE

I understand that I have the right to revoke this authorization at any time. I understand that my revocation must be in writing and addressed to the privacy office of the above named facility authorized to make this disclosure. I understand that the revocation does not apply to information already released in response to this authorization.

I understand that any disclosure of information may be subject to re-disclosure by the recipient and may no longer be protected by federal or state law. I understand that I need not sign this authorization to assure continued treatment. I understand that I may inspect and / or copy the information to be disclosed. I understand that authorizing this is voluntary. I understand that if I have questions about disclosure of my health information, I may contact the privacy officer at the facility listed above that is authorized to disclose this information and request a copy of this authorization.

I understand that there may be a fee for this service.

Requests cannot be processed without proper authorization. Minors must have a parent's signature. Individuals requesting records on adult patients must provide the required Power of Attorney or other supporting legal documents.

_____ _____

Signature of Patient or Authorized Representative Date

Fax Request to (860) 823-2949