AUTHORIZATION TO DISCLOSE HEALTH INFORMATION (MEDICAL RECORDS RELEASE)

Patient Name:_____ Date of Birth:_____

1. I authorize the use or disclosure of the above named individual's health information as described below.

2. The following individual or organization is authorized to make the disclosure:

Address_____
_____

3. The type and amount of information to be used is as follows: (Include dates where applicable).

☐ Most Recent History and Physical

☐ Most Recent Office Visit/Service Bill

☐ Laboratory results from (date)_____to (date)_____

☐ X-Ray and Imaging Reports from (date)_____to (date)_____

☐ Consultation Reports from doctor's name)_____

☐ Entire Record(s)

Other_____
_____
_____

4. I understand that the information in my health record may include information relating to sexually transmitted disease, acquired immunodeficiency syndrome (AIDS) or human immunodeficiency virus (HIV). It may also include information about behavioral or mental health services, and treatment for alcohol and drug abuse.

5. This information may be disclosed to and used by the following individual organization:

Address:_____
_____
For the purpose of_____

6. I understand that I have a right to revoke this authorization at any time. I understand that if I revoke this authorization I must do so in writing and present my written revocation to the Receptionist. I understand that the revocation will not apply to information that has already been released in response to this authorization. I understand that the revocation will not apply to my insurance company when the law provides my insurer with the right to contest a claim under my policy. Unless otherwise revoked, this authorization will expire on the following date, event, or condition:_____. If I fail to specify an expiration date, event or condition, this authorization will expire in six (6) months.

7. I understand that authorizing the disclosure of this health information is voluntary. I can refuse to sign this authorization. I need not sign this form in order to assure treatment. I understand that I may inspect or copy the information to be used or disclosed, as provided in CFR 164.524. I understand that any disclosure of information carries with it the potential for an unauthorized re-disclosure and the information may not be protected by federal confidentiality rules. If I have questions about disclosure of my health information, I can speak with any staff member.

_____ _____
Signature of Patient or Legal Representative Date

_____ _____
If Signed By Legal Representative, Relationship to Patient Redding Orthopedic Center (Representative)