Name:
DOB:
Account:
Age:
Date:

orthopaedicseast
& SPORTS MEDICINE CENTER

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www.orthoeast.com

AUTHORIZATION TO USE OR DISCLOSE PROTECTED HEALTH INFORMATION

I authorize Orthopaedics East & Sports Medicine Center to use or disclose a copy of the specific health information identified below for:

Patient: _____ DOB: _____

Address: _____ City: _____

State: _____ Zip Code: _____ Last 4 #s SSN: _____

Home Phone: _____ Cell Phone: _____

PATIENT INFORMATION TO BE RELEASED FOR PURPOSE(S) OF:

☐ Continuing Medical Care ☐ Military ☐ Insurance ☐ School ☐ Disability Form

☐ Soc Security Disability ☐ Personal Use ☐ Legal Purposes ☐ Other _____

INFORMATION TO BE RELEASED

☐ Entire Medical Record ☐ Office Visit Notes ☐ History & Physical ☐ Operative Reports

☐ Lab/Path Reports ☐ X-Ray Reports/Images ☐ Physical Therapy Notes

☐ MRI Reports/Images ☐ Other: _____

Dates of Service Requested: From _____ To _____

RECEIVING PARTY INFORMATION

These records are for: ☐ Patient ☐ Physician ☐ Other _____

These records are to be: ☐ Picked Up ☐ Mailed ☐ Faxed

Mailing address, if different than address listed above:

Name: _____

Address: _____ City: _____

State: _____ Zip Code: _____ Phone Number: _____

Fax Number: _____

I understand that, if the person or organization receiving this information is not a healthcare provider, health care organization, or health plan covered by federal regulations, then this information may be redisclosed and no longer protected by federal or state law.

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 my treatment, payment for treatment and my enrollment or eligibility for benefits cannot be conditioned on the signing of this authorization.

I understand that I may revoke this authorization in writing at any time, provided that I do so in writing, except to the extent that action has been taken upon this authorization. Unless revoked earlier, this authorization to use or disclose my health information will expire five years from the date of this authorization.

Patient Signature: _____ Date: _____

Personal Representative Signature: _____ Date: _____

Relationship to Patient: _____

Copy given to Patient by: _____ Identification verified: ☐ Yes ☐ No

Please note: Orthopaedics East & Sports Medicine Center will provide the patient with a copy of his/her medical records at no-cost as a courtesy for the first request. **If records are requested for a second time, there will be a $10.00 fee.** Records sent directly to a physician's office involved in your medical care will be provided at no-cost.