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DownEast ORTHOPEDICS

AUTHORIZATION TO RELEASE PROTECTED HEALTH INFORMATION

Patient Name (*Please Print*)**:**_____**DOB:**_____

As specified below, I hereby authorize DownEast Orthopedics and its authorized employees and agents to:

□ **Release medical records to** (Patient; legal guardian, medical provider):
□ **Obtain medical records from** (Medical provider):

Organization/Clinic Name: _____

Mailing address: _____

City: _____ **State:**_____ **Zip Code:**_____

Fax: _____ **Phone:**_____

Records to Be: **Mailed:**☐ **Faxed:**☐ **Picked up:**☐

Emailed to:☐ _____

The specific information I want disclosed includes:
□ All health information pertaining to (*Specify body part*):_____

OR *only* release indicated records pertaining to (*Specify body part*):_____

□ Office visit notes □ Laboratory reports □ Operative reports
□ Therapy notes □ EMG report □ Imaging/Radiology reports
□ Other (*Please specify*):_____

Dates of Service (*Example – last 3 years*):_____

This disclosure is for the purpose of: _____

My specific permission is required to disclose information regarding HIV test results or status. *I understand that authorizing the release of such information does not confirm the existence of such history or treatment.*
Check one of the options below and initial at end to confirm your choice:

□ **I DO** authorize disclosure of information which refers to HIV test results, infection status or treatment information. **Intials:** _____
□ **I DO NOT** authorize disclosure of information which refers to HIV test results, infection status or treatment information. **Initials:** _____

I understand that:
♦ I am not required to sign this form and that I may refuse to disclose all or some of the above healthcare information in my treatment records, but that refusal may result in improper diagnosis or treatment, denial of coverage for a claim for health benefits, denial of other insurance, or other adverse consequences.
♦ PHI released pursuant to this authorization may include records generated by another healthcare provider or facility.
♦ I further understand that I may withdraw my authorization at any time except to the extent that action has been taken in reliance on this authorization. I understand that if I revoke this authorization, I must do so in writing.
♦ PHI used or disclosed pursuant to this authorization may be re-disclosed by the recipient and no longer protected by confidentiality laws.
♦ I am entitled to a copy of this authorization, upon request.
EXPIRATION: This authorization becomes effective immediately and shall expire one year from the date of signing.

SIGNED: _____**Date:** _____
(patient or his/her legally appointed representative)