ISLAND ORTHOPAEDICS

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# AUTHORIZATION FOR USE AND DISCLOSURE OF PROTECTED HEALTH INFORMATION

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|---|---|
| **Patient Information** | Name ______ Social Security Number ______<br>Address ______ Birthdate ______<br>City ______ State ______ Zip Code ______ Phone ______ |
| **Hospital / Clinic / Health Care Provider** (Who has the information you want released?) | Name ______ Specialty ______<br>Address ______ Phone ______<br>City ______ State ______ Zip Code ______ Fax ______ |
| **Receiving Party** (Where do you want the information sent?) | Name ______ Representative Capacity ______<br>Address ______ Phone ______<br>City ______ State ______ Zip Code ______ Fax ______ |
| **Information To Be Released** (What information do you want released?) | Date range From: ______ To: ______<br>☐ Island Orthopaedicsclinical notes ☐ Medical bills ☐ Hospital operative report<br>☐ Radiology images & reports ☐ Physical therapy reports ☐ Hospital consult summary<br>☐ Laboratory & pathology results ☐ Medication information ☐ Other: ______ |
| **Special Consent** If this section is left incomplete, information relating to this material will not be released. | I understand this health information may include HIV- related information and/or information relating to diagnosis or treatment of psychiatric disabilities and/or substance abuse (see 42 CFR 2.31) and that by signing this section, I am specifically authorizing the release of information relating to:<br>☐ Substance abuse ☐ HIV - related Information (including AIDS related testing)<br>☐ Mental health ☐ Psychotherapy notes<br>Signature: ______ Date: ______ |
| **Release Instructions** | Date information is needed: ______ (Please allow 5-7 days for Processing)<br>☐ Via US Postal Service ☐ Will pick up in person ☐ Fax to receiving party at above number |
| **Purpose of Release** | ☐ Personal use ☐ Litigation / legal purposes* ☐ Social Security disability determination*<br>☐ Continuing care ☐ Insurance payment / claim ☐ Social Security appeal<br>☐ Transfer of care ☐ Insurance application* ☐ Other: ______ |

I have read and understand the following: See CFR §164.508(c)(2)(i-iii)

This authorization will last for one year from date of signature or for a lesser period if specified here: ______ to ______. Initials: ______

I may revoke this authorization at any time by providing notification in writing to Island Orthopaedics, LLC and it will be effective on the date received, except to the extent action has already been taken and information has been released in reliance upon this authorization.

An electronic copy of this authorization will be treated in the same manner as the original.

I understand that if information containing PHI is released pursuant to this authorization, Island Orthopaedics, LLC can no longer guarantee confidentiality or prevent re-disclosure, and the information may no longer be protected by federal privacy rules.

I authorize Island Orthopaedics, LLC and its employees to disclose the above described PHI to the person(s) or entity identified above as the "Receiving Party" in accordance with the "Release Instructions" provided herein.

I further understand that my healthcare and payment for my healthcare will not be affected if I do not sign this form.

By signing this authorization, I agree to release Island Orthopaedics, LLC from any and all liability related to disclosure or re-disclosure of my PHI.

Records released for purposes marked with an * may be charged a fee of $1.00 USD per page plus tax

______ ______ ______

Signature of Patient or Authorized Party *(See 45CFR § 164.508(c)(1)(vi))* Print Name Date

______

Relationship to Patient if Authorized Party (please attach legal document if applicable) *(See 45CFR §164.508(c)(1)(iv))*

______ ______ ______

Signature of Witness Print Name Date