

AUTHORIZATION FOR USE AND DISCLOSURE OF PROTECTED HEALTH INFORMATION

Patient Information	Name _____ Social Security Number _____ Address _____ Birthdate _____ City _____ State _____ Zip Code _____ Phone _____
Hospital / Clinic / Health Care Provider <small>(Who has the information you want released?)</small>	Name _____ Specialty _____ Address _____ Phone _____ City _____ State _____ Zip Code _____ Fax _____
Receiving Party <small>(Where do you want the information sent?)</small>	Name _____ Representative Capacity _____ Address _____ Phone _____ City _____ State _____ Zip Code _____ Fax _____
Information To Be Released <small>(What information do you want released?)</small>	Date range From: _____ To: _____ <input type="checkbox"/> Island Orthopaedics clinical notes <input type="checkbox"/> Medical bills <input type="checkbox"/> Hospital operative report <input type="checkbox"/> Radiology images & reports <input type="checkbox"/> Physical therapy reports <input type="checkbox"/> Hospital consult summary <input type="checkbox"/> Laboratory & pathology results <input type="checkbox"/> Medication information <input type="checkbox"/> Other: _____
Special Consent <small>If this section is left incomplete, information relating to this material will not be released.</small>	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: <input type="checkbox"/> Substance abuse <input type="checkbox"/> HIV - related Information (including AIDS related testing) <input type="checkbox"/> Mental health <input type="checkbox"/> Psychotherapy notes Signature: _____ Date: _____
Release Instructions	Date information is needed: _____ (Please allow 5-7 days for Processing) <input type="checkbox"/> Via US Postal Service <input type="checkbox"/> Will pick up in person <input type="checkbox"/> Fax to receiving party at above number
Purpose of Release	<input type="checkbox"/> Personal use <input type="checkbox"/> Litigation / legal purposes* <input type="checkbox"/> Social Security disability determination* <input type="checkbox"/> Continuing care <input type="checkbox"/> Insurance payment / claim <input type="checkbox"/> Social Security appeal <input type="checkbox"/> Transfer of care <input type="checkbox"/> Insurance application* <input type="checkbox"/> 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