The Centers for Advanced Orthopaedics

The Orthopaedic Foot & Ankle Center

Authorization to Release/Disclose Protected Health Information

Patient Name: _____ Date of Birth: _____

Phone Number: _____ Social Security #: _____

Address: _____

Street Address City State Zip Code

I authorize The Orthopaedic Foot and Ankle Center, a division of The Centers for Advanced Orthopaedics to release or disclose the following information to:

☐ Physician ☐ Other _____

_____ Phone # (required if faxing): _____

Name of person or entity to receive information Fax # (25 pages of less): _____

_____

Street Address City State Zip Code

Information to be Released/Disclosed:

☐ Complete Medical Record

☐ Specific Date(s) of service: _____

☐ Billing Information

☐ Other _____

Part of Medical Records:

☐ Laboratory Reports

☐ Operative Reports

☐ Pathology Reports

☐ Radiology Reports

☐ Physician Orders

☐ Radiology Images/CD

**Note: If these records contain any information from previous providers or information about HIV/AIDS status, cancer diagnosis, drug/alcohol abuse, or sexually transmitted disease, you are hereby authorizing disclosure of this information.

Purpose:

☐ Medical Follow-up

☐ Attorney

☐ Personal Use

☐ Insurance

☐ Other _____

Record Disposition:

☐ Please mail the records

☐ Fax to number above

☐ I will pick up the records

☐ Send to Patient Portal (no charge)

Fees + Postage (If applicable):

Retrieval Fee: $10.00

Pages 1-50: $0.50 per page

Pages 51+: $0.25 per page

Radiology images on CD: $10.00

Continuing care: No charge

**Fees must be paid prior to release of records

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 1 year from date signed.

I understand if the person or agency that receives my information is not a health care provider or health plan covered by the HIPAA privacy regulations, the information described above may be redisclosed and is no longer protected by these regulations.

_____ _____

Signature of Patient or Authorized Representative Date

_____ _____

Print Name of Patient or Authorized Representative Relationship to Patient