SOUTHWEST ORTHOPAEDIC SURGERY SPECIALISTS, PLC.

ANKLE & FOOT CENTER • SPORTS MEDICINE CENTER

Print

Consent to Release Medical Records

THIS FORM AUTHORIZES THE RELEASE OF YOUR MEDICAL INFORMATION FROM OTHER PHYSICIANS AND HEALTH CARE PROVIDERS. COMPLETE THIS FORM IF SOUTHWEST ORTHOPAEDIC SURGERY SPECIALISTS REQUIRES THE RELEASE OF YOUR MEDICAL RECORDS.

Patient Name: ____ Birth Date: ________________________

Address: ____

Records From:____

Address: ____

Phone Number: ____ Fax Number: ______________________

Release Information To: ____

Address: ____

Phone Number: ____ Fax Number: ______________________

MEDICAL RECORDS TO BE RELEASED:

(Please initial)

_____ Specific Injury: ________________________________ Date of Injury: ______________________

_____ X-Rays (Must Be Returned)

_____ Entire medical record (this will include ANY and all records)

_____ Hospital records, including nursing records and progress notes

_____ Transcription of hospital reports

_____ Medical records needed for continuity of care

_____ Laboratory reports

_____ Most recent five-year history

_____ Pathology reports.

_____ Emergency and urgent care records

_____ Diagnostic imaging reports

_____ Clinician office chart notes

_____ Billing statements

THE FOLLOWING ITEMS MUST BE INITIALED TO BE INCLUDED IN THE USE OR DISCLOSURE OF OTHER HEALTH INFORMATION

(Please initial)
_____ HIV/AIDS related health information and/or records

_____ Mental health information and/or records

_____ Genetic testing information and/or records

_____ Drug/Alcohol diagnosis, treatment and/or referral information

Federal regulations require a description of how much and what kind of information is to be disclosed. Federal law prohibits the re-disclosure of such information. This authorization shall be considered invalid after six months (60 days for drug and alcohol abuse records) from the date of signing. Medical information or records gathered after the date of authorization signing is not to be released.

I may revoke this authorization at any time, but not retroactively to the release of information made in good health. I also understand that, if the person or entity receiving this information is not a health care provider or health plan covered by federal privacy regulations, the information described above may be re-disclosed and no longer protected by these regulations. However, the recipient may be prohibited from disclosing my health information under other applicable state or federal laws and regulations.

I further understand that the person(s) I am authorizing to use or disclose my medical records or health information may receive compensation (either directly or indirectly) for doing so.

____ ______________
Signature of Patient Date

If patient is unable to sign, give reason: ____

____________________________________ _________________ ______________
Signature of Legally Authorized Representative Relationship to Patient Date

____ ______________
Witness Signature Date

Date Completed: ______________________________ By: _____________________________