Authorization for Release of Medical Record Information

Patient Name: ____D.O.B.: _____ /______ /______

Address: ____

Street City State Zip

Telephone: ______________________________________

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The above listed patient authorizes ____

Health care facility/Physician

to release medical records to ____

Health care facility/Physician

☐ Please fax records to: ___________________________

☐ Please mail records to: ____

Type of information to disclose: ☐ Office notes ☐ Imaging reports ☐ CD of x-ray(s)

☐ Other ____

Dates to disclose: _________________________________

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When requesting records FROM Litchfield County Orthopedic & Spine, PC:

Restrictions: Only medical records originated through this heath care facility will be copied unless otherwise requested. This authorization is valid only for the release of medical information dated prior to and including the date on this authorization unless other dates are specified.

I understand the information in my health record may include information relating to sexually transmitted disease, acquired immunodeficiency syndrome (AIDS), or human immunodeficiency virus (HIV). It may also include information about behavioral or mental health services, and treatment for alcohol and drug abuse.

I understand I may revoke this authorization at any time. I understand that if I revoke this authorization I must do so in writing and present my written revocation to the office manager. I understand that the revocation will not apply to information that has already been released in response to this authorization. I understand that the revocation will not apply to my insurance company when the law provides my insurer with the right to contest a claim under my policy.
This authorization will expire 1 year from the date signed.

I understand that authorizing the disclosure of this health information is voluntary. I can refuse to sign this authorization. I need not sign this form in order to assure treatment. I understand that I may inspect or obtain a copy of the information to be used or disclosed, as provided in CFR 164.524. I understand that any disclosure of information carries with it the potential for an unauthorized re-disclosure and the information may not be protected by federal confidentiality rules. If I have questions about disclosure of my health information, I can contact the authorized individual or organization making disclosure.

I have read the above foregoing Authorization for Release of Information and do hereby acknowledge that I am familiar with and fully understand the terms and conditions of this authorization.

X ____ ______________________________

Signature of Patient / Parent / Guardian or Authorized Representative **Date**

(Guardian or Authorized Representative must attach documentation of such status)

____ ______________________________

Printed name of Authorized Representative Relationship / Capacity to patient Date