CRESCENT CITY ORTHOPEDICS

Authorization for Release of Protected Health Information

1. **Patient Information**

Patient Name _____ Date of Birth _____/_____/_____

Patient Address_____
Street City State Zip

Patient Phone # _____ Patient Email _____

2. **Recipient Authorization**

I _____ hereby authorize Crescent City Orthopedics to release a copy of my medical record to _____
Address: _____
Phone _____ Fax _____

3. **Information to be Released.** Check all that apply and specify dates of service.

( ) Entire Medical Record _____ ( ) Lab Reports_____
( ) Visit Notes_____ ( ) X-Ray Reports_____
( ) Pathology Reports_____ ( ) Other (specify)_____
( ) Psychotherapy Notes _____ (If so, this is the only item you may request on this authorization)

4. **Purpose of Information Release**

( ) Further medical care
( ) Payment of Insurance Claim
( ) Legal Investigation
( ) Applying for Insurance
( ) Disability Determination
( ) Vocational rehab, evaluation
( ) At the request of the individual
( ) Other (specify):_____

5. **Inclusion of Privileged Information**

I understand that if my record contains information concerning alcohol or drug abuse/treatment, information concerning abortion, HIV testing and related information, AIDS-related conditions, genetic testing, STDs, domestic/sexual abuse, or developmental disabilities, such information is included in this disclosure.

6. **Patient Rights and Privacy**

- I understand that I do not have to sign the authorization in order to receive treatment or payment, or to enroll or be eligible for benefits. I understand that I may revoke this authorization at any time, except to the extent that the individual or entity that is to make the disclosure has already completed action on it.
- I understand that protected health information disclose pursuant to this authorization may be re-disclosed by the recipient to other individuals or organizations that are not subject to privacy protection laws.
- I understand that I may see and obtain a copy of the information described on this form, for a reasonable copy fee, if I request it.
- I understand that Crescent City Orthopedics will not condition treatment on whether I sign the authorization. This authorization will automatically expire one year from the date signed.

Signature of Patient: _____Date: _____

Signature of Legal Representative: _____Date: _____

Relationship to Patient:_____