THE ORTHOPEDIC PARTNERS
AN RCM AFFILIATE
PARK CITY | HEBER CITY | SALT LAKE CITY

900 Round Valley Drive, Suite 100, Park City, Utah 84060
T 435-655-6600 | F 435-655-2388
medrecords@toportho.com Monday - Friday **8 am - 5 pm**

Authorization for Protected Health Information

Patient Name:

Address: City: State: Zip:

Phone: Social Security: Birth Date:

I authorize access of my information to the following: (self or choose up to two recipients)

Self or Name:

Phone #:

*Choose **one** of the following options:*

☐ Email:

☐ Fax:

☐ Mailing Address:

Fee for printed records $25.00 + postage

Self or Name:

Phone #:

*Choose **one** of the following options:*

☐ Email:

☐ Fax:

☐ Mailing Address:

Fee for printed records $25.00 + postage

Purpose:

☐ Continuation of Care ☐ Insurance ☐ Legal ☐ Personal Use ☐ Other:

For treatment Date(s): to **or if no dates are specified, the last two (2) years will be released.**

Medical Data/Information:

☐ Whole Chart *OR select specific records:*

☐ Visit Notes
☐ Operative Report
☐ X-ray Images (Email)
☐ X-ray Images (CD)
Available upon request. Charges may apply.
☐ Other:

By signing this authorization, I understand that:

- The authorization form is in effect until revoked by me, or until any records retention period applicable to my records has expired, whichever is sooner.
- Electronic media and delivery methods such as e-mail pose certain risks to the privacy and security of my PHI that may be beyond the control of The Orthopedic Partners. I agree to assume such risks personally and hold The Orthopedic Partners harmless in the event my PHI is breached or compromised as a result of my directing and authorizing The Orthopedic Partners to transmit or deliver such information electronically.
- I have the right to revoke this authorization by written notice to The Orthopedic Partners. I understand actions taken in reliance of the authorization cannot be reversed and my revocation will not affect those actions.
- There may be costs associated with this request in compliance with state copying laws.
- If I sign this form, my health care, the payment for my health care or my ability to enroll for benefits will not be affected.

Patient or Authorized Representative Signature Date Relationship