



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)

Other: _____

*Available upon request.
Charges may apply.*

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 _____