



Doctor: \_\_\_\_\_ Chart # \_\_\_\_\_

I hereby authorize the use or disclosure of my individually identifiable health information as described below. I understand this authorization is voluntary.

I understand that if the organization authorized to receive the information is not a health plan or health care provider, the released information may no longer be protected by federal privacy regulations, and that it may be re-disclosed by the recipient.

Patient Name: \_\_\_\_\_ Date of Birth: \_\_\_\_\_

Phone #: \_\_\_\_\_

Organization Providing the Information: \_\_\_\_\_

Address: \_\_\_\_\_

Organization(s) or Person(s) Receiving the Information:

Specific Description of Information Disclosed:  Complete Medical Record

Progress Notes  Operative Reports  Imaging / Lab Reports  X-Ray

Other \_\_\_\_\_

To the extent any of the following information is contained in my records being released, I specifically authorize the release of such information for the purposes indicated below by initialing before each category:

Initials: \_\_\_\_\_ HIV / AIDS testing, test results, treatment and related information including high risk behavior documented;

Initials: \_\_\_\_\_ drug and / or alcohol diagnosis, treatment, test results and reports and referral information;

Initials: \_\_\_\_\_ mental health treatment information, test results and reports including psychological and psychiatric studies, reports, evaluations and referral information; and / or

Initials: \_\_\_\_\_ venereal disease information;

Initials: \_\_\_\_\_ genetic testing, test results, counseling, reports, treatment, and referral information.



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Patient Name: \_\_\_\_\_ Date of Birth: \_\_\_\_\_

Phone #: \_\_\_\_\_

Purpose of Disclosure:    \_\_\_ Moving Out of Area    \_\_\_ Disability Application  
\_\_\_ Insurance Request    \_\_\_ Patient    \_\_\_ Choosing a New Physician  
\_\_\_ Other

You must read and initial the following statements:

1. I understand this Authorization will expire 7 YEARS FROM DATE OF SIGNATURE or on the following event: Termination of the Physician / Patient Relationship.

Initials: \_\_\_\_\_

2. I understand that I may revoke this Authorization at any time by notifying Orthopedic Institute of Pennsylvania's Privacy Officer in writing, but if I do, it will not have any effect on any actions Orthopedic Institute of Pennsylvania took before they received the revocation.

Initials: \_\_\_\_\_

**This Authorization will NOT be accepted unless it is completed in its entirety.**

Signature of Patient or Representative \_\_\_\_\_

Last Four Digits Patient SS# \_\_\_\_\_

Patient Phone # \_\_\_\_\_

Relationship to Patient \_\_\_\_\_ Date \_\_\_\_\_

You may refuse to sign this Authorization. We cannot condition treatment on your signing this Authorization.

Patient Received on (date): \_\_\_\_\_ Patients Initials: \_\_\_\_\_ OIP Initials: \_\_\_\_\_

Pick Up: \_\_\_\_\_ Mail To: \_\_\_\_\_

Route To: \_\_\_\_\_ Medical Records \_\_\_\_\_ Billing \_\_\_\_\_ X-Ray Revised 01/11/09