Name: _____

Date of Birth: _____

Date: _____

ANDREWS
Sports Medicine & Orthopaedic Center

Medical Records Release and Authorization for Use or Disclosure of Protected Health Information

I authorize the custodian of records of Andrews Sports Medicine & Orthopaedic Center or other person/entity (specifically describe)_____to release/disclose the following information (check all applicable):

☐ Office Notes ☐ Laboratory/pathology records ☐ X-Ray film ($5 charge) ☐ MRI Report ☐ CT Report ☐ H&P

☐ Operative Reports ☐ Discharge Summary ☐ Pharmacy/Rx records ☐ Billing records

☐ Other (describe specifically)_____

Records requested are for service(s) provided on the following date(s) or range of dates:_____

Forward to: ☐ I Prefer to pickup my records. Contact me once available: _____

Name:_____ Name:_____

Address:_____ Address:_____

_____ _____

Phone:_____ Phone:_____

Fax:_____ Fax:_____

The information may be used/disclosed for each of the following purposes:

☐ At my request (only the patient can check this box) ☐ For employment purposes ☐ For my healthcare ☐ For payment/insurance

☐ Other:_____

- This authorization will expire at the end of the calendar year of your last signature below, unless you specify an earlier termination. You must renew or submit a new authorization after the expiration date to continue the authorization. Please list the date of expiration if earlier than the end of the calendar year: _____
- You have the right to terminate this authorization at any time by submitting a written request to our Privacy Manager. Termination of this authorization will be effective upon written notice, except where a disclosure has already been made based on prior authorization.
- The practice places no condition to sign this authorization on the delivery of healthcare or treatment.
- We have no control over the person(s) you have listed to receive your protected health information. Therefore, your protected health information disclosed under this authorization may no longer be protected by the requirements of the Privacy Rule, and will no longer be the responsibility of the practice.

"Andrews Sports Medicine and Orthopaedic Center complies with applicable Federal Civil rights laws and does not discriminate on the basis of race, color, national origin, age, disability or sex".

Patient Name: _____ **Signature of patient:** _____

DOB: _____ **Date:**_____

If patient is over 14 years of age, this must be signed by the patient.

You have the right to revoke this authroization, except to the extent that the custodian of records has relied on it, by sending your written request to the Privacy Officer.