Request for Protected Health Information / Patient Authorization for Release of Records

Patient Name: _____ S.S. # _____

Date of Birth _____ Patient Phone Number(s): _____ MR/Chart Number _____

PERSON(S) / ORGANIZATION(S) AUTHORIZED TO MAKE DISCLOSURE:

Dallas Orthopedic & Shoulder Institute or

_____

_____

RELEASE INFORMATION TO: (*recipient of disclosure*)

Name: _____
Address: _____
Apt, Suite or PO #: _____
City, State, and Zip: _____
Phone: _____
Fax: _____

***There is a charge for records. If records are being requested to be sent to a lawyer, insurance or workers compensation company, please have them contact us with a written request; otherwise the patient will be charged.**

TREATMENT DATES TO BE DISCLOSED: _____

PURPOSE OF THE DISCLOSURE: ☐ Insurance ☐ Legal ☐ Continuing Care ☐ Personal ☐ other (specify) _____

SPECIFIC DESCRIPTION OF THE INFORMATION TO BE DISCLOSED:
☐ Clinic Notes ☐ Radiology ☐ Therapy Notes ☐ Radiology Films ☐ Other _____

SPECIFIC INFORMATION TO **NOT** BE DISCLOSED: _____

I understand that the purpose of this authorization is for the use and/or disclosure of my protected health information (PHI) and that it may contain information that is protected under state laws and federal regulations. I understand that one the above information is disclosed it may be subject to re-disclosure and will no longer be protected by Privacy Protection Rules. I understand that I have the right to revoke this authorization at any time and that my revocation must be submitted to the medical record department at Dallas Orthopedic & Shoulder Institute I understand that my revocation is not effective to the extent that the persons or organizations in which I have authorized to use and/or disclose my protected health information have acted in reliance upon this authorization. I understand that I may refuse to sign this authorization and my refusal to sign will not affect my ability to receive treatment, payment enrollment, or eligibility for benefits. I understand that I will be given a copy of this authorization upon my signature.

I hereby authorize Dallas Orthopedic & Shoulder Institute to disclose/release medical records and other information obtained in the course of my diagnosis and/or treatment. I agree to pay copy charges if applicable.

I hereby release Dallas Orthopedic & Shoulder Institute from any liability which may result from this disclosure of confidential medical information or which may arise of the result of the use of the information contained in the information released. Unless withdrawn, this consent will expire 90 days from the date signed.

This information may include Medical/Surgical, and other information.

I authorize that this information may be ☐ picked up in person, or ☐ faxed to _____ when applicable.

_____ _____
PATIENT'S SIGNATURE **DATE**

_____ _____
PATIENT'S REPRESENTATIVE SIGNATURE AND AUTHORITY TO SIGN **DATE**

_____ _____
WITNESS **DATE**