

St. Peters
Bone & Joint
Surgery

GENERAL ORTHOPEDICS • SPINE • SPORTS MEDICINE
FOOT & ANKLE SURGERY • JOINT REPLACEMENT • HAND SURGERY

AUTHORIZATION FOR RELEASE OF MEDICAL RECORDS (PHI)

Instructions:

All blank spaces must be filled and boxes checked. Any blank spaces and/or boxes that have not been completed will render this Authorization incomplete and, therefore, defective. Defective Authorization forms will be returned to you and no records will be released.

This request for disclosure of medical information is made at my request for the purpose of

I authorize _____ to:

- Release Medical Records Obtain Medical Records
 Release Billing Records
 Release Films or CDs

Specific information to be released: _____.

Dates of service: from _____ to _____.

Patient's full name _____
Last First Middle Initial

Date of birth _____ Social Security Number _____

Patient address _____
Street Address

City State Zip code

Patient home phone _____ Cell phone _____

TO / FROM

Name of physician / facility / agency

Street Address

City State Zip code

Telephone number Fax number

St. Peters Bone & Joint Surgery

GENERAL ORTHOPEDICS • SPINE • SPORTS MEDICINE
FOOT & ANKLE SURGERY • JOINT REPLACEMENT • HAND SURGERY

I understand that this authorization will expire one (1) year from the date signed.

I understand that I may revoke this Authorization at any time by notifying the providing organization in writing, except to the extent the organization has taken action in reliance on the consent.

I understand that if the organization authorized to receive the information is not a health plan or healthcare provider covered by federal privacy regulations, the release of such information may no longer be protected by federal privacy regulations.

I understand that I am under no obligation to sign this form and that the person(s) and/or organization(s) described above to whom I am authorizing to use and/or disclose my health information may not condition treatment, payment, enrollment in a health plan or eligibility for healthcare benefits on my decision to sign this Authorization.

I permit the release of all information indicated above, including, if any, all information concerning drug/alcohol treatment or use, AIDS/HIV or other communicable diseases, mental and behavioral health or sexually transmitted diseases.

Signature of Patient

Date

.....
Patient is unable to sign because:

Name of personal representative _____

Relationship to patient _____

Street address _____

City, State Zip _____

Telephone number _____

Cell phone number _____

Authority of Personal Representative _____

(e.g. healthcare power of attorney, guardian, other statutory authorization, must provide legal documentation)

Signature of Personal Representative

Date