Patient Health Information Release Authorization

****Before you sign, please note that there is a $0.12 per page fee and a $6.50 per Xray CD****
Please initial that you are aware of charges to obatin records **BEFORE** you sign _____

I, _____, hereby authorize Capital Region Orthopaedics to disclose my health information under the terms described below. Pursuant to this authorization, my health information may be disclosed to, and used by, the following individual or organization:

I want the following information for: (please check one)

◯ **Myself** ◯ **Other**

This information may be disclosed to and used by the following individual or organization:

Name:_____

Address: _____

City, State, Zip:_____

Phone Number: _____

For the purpose :◯ Continuity of Care ◯ Legal Matter ◯Insurance ◯ Personal
EXCEPTIONS TO THE ABOVE: I DO NOT AUTHORIZE THE RELEASE OF THE FOLLOWING:
◯MENTAL HEALTH ◯ SUB. ABUSE/ALCOHOL ◯HIV/AIDS ◯DOMESTIC/SEXUAL ABUSE

Dates of records requested: From_____ **to** _____

Records Requested:

Progress Notes ◯ **X-Ray Disc** ◯

All records ◯ **All records w/ disc** ◯

Other_____◯

Patients Signature:_____**DOB:**_____ Date:_____

Parent or Guardian Signature:_____ Date:_____

****THIS AUTHORIZATION WILL BE CONSIDERED INVALID WITHOUT A SIGNATURE AND DATE****
please read the back before signing

I understand that if my records contain information relating to sexually transmitted disease, acquired immunodeficiency syndrome (AIDS) or human immunodeficiency virus (HIV)related information, such information indicating that an HIV test was done; HIV virus is present; HIV related illness or AIDS; any information which could indicate that a person has been potentially exposed to HIV. I also understand that if my records contain information concerning***: DRUG, ALCOHOL ABUSE AND/OR TREATMENT OR BEHAVORIAL, MENTAL HEALTH SERVICES OR PSYCHIATRIC TREATMENT, DOMISTIC/SEXUAL ABUSE***, such information will be released pursuant to this authorization.

UNLESS OTHERWISE REVOKED, this authorization will expire in 90 days.

I understand that I have the right to revoke this authorization I must do so in writing and present my written revocation to the medical facility. I understand that the revocation will not apply to information that has already been released in response to this authorization. I understand that the revocation will not apply to my insurance company when the law provides my insurer with the right to consent claim under my policy. I understand that authorizing disclosure of health information is voluntary. I can refuse to sign this authorization. I need not to sign this form in order to ensure treatment. I understand that I may inspect a copy of the information to be used or disclosed, as provided in the **CFR161.524**. I understand that any disclosure of information carries with it the potential for an unauthorized re-disclosure, and the information may not be protected by federal confidentially rules. If I have any questions about disclosure of my health information, I can contact the medical facility or its agent: CIOX HEALTH Technologies at (800)367-1500

DO YOU UNDERSTAND YOUR RIGHTS?

- YES I DO _____(please initial)
- NO, I DO NOT WANT TO SIGN _____(please initial)