ARLINGTON ORTHOPEDIC ASSOCIATES, P.A.

AUTHORIZATION TO DISCLOSE PROTECTED HEALTH INFORMATION

Patient Full Name: _____ Date: _____

Date of Birth: _____ Referring Physician: _____

Address: _____

I HEREBY AUTHORIZE ARLINGTON ORTHOPEDIC ASSOCIATES TO DISCLOSE MY PROTECTED HEALTH INFORMATION TO:

Person/Organization Name: _____

Address: _____

City: _____ State _____ Zip Code: _____

Phone: (_____)_____ Fax: (_____)_____ Email: _____

SEND VIA:

□ E-mail □ Mail □ Fax □ Pick-Up

Email: hamoore@arlingtonortho.com

Fax: 817-299-1715 *ATTN: Hayley*

WHAT INFORMATION CAN BE DISCLOSED:

□ All Health Information
□ Office Notes □ All □ Date: _____ to _____
□ Physician Orders
□ Radiology Report: _____ □ All □ Date/Image_____
□ MRI Reports □ MRI/X-ray CD □All □ Date/Image_____
□ Operative Reports
□ Hospital Reports
□ Other_____

REASON FOR DISCLOSURE:

□ Treatment/Continuing Medical Care □ Personal Use □ Disability □ Billing or Claims □ Legal □ School
□ Employment □ Other_____

RELEASE OF RECORDS DIRECTLY TO PATIENT: I understand that my medical record may contain reports, test results, and notes that only a physician can interpret. I understand and have been advised that I should contact my physician regarding the entries made in my medical record to prevent misunderstanding of the information contained in these entries. I will not hold Arlington Orthopedic Associates, P.A. and its Physicians liable for any misinterpretation of the information in my medical record as a result of not consulting my physician for the correct interpretation. Initial: _____

I have read this form and agree to the uses and disclosures of information as described. I agree that a photocopy of this authorization shall be as valid as the original. I understand that information disclosed pursuant to this authorization may be subject to re-disclosure by the recipient and may no longer be protected by the federal or state law. I do not have to sign this authorization in order to receive treatment. I also understand that I have the right to revoke this authorization at anytime. I understand that if I revoke this authorization I must do so in writing and present my revocation to the Privacy Officer at Arlington Orthopedic Associates, PA. I understand that the revocation will not apply to information already 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 contest a claim under my policy. Unless otherwise revoked, this authorization expires one year from the date of this request or upon the following date: _____. Initial_____

_____ _____/_____/_____ (_____)_____

Print Patient's Name Date Telephone Number

_____ _____

Signature of Patient or Legal Guardian Relationship to Patient (Legal Representation)