AUTHORIZATION FOR USE FOR DISCLOSURE OF HEALTH INFORMATION

Completion of this document authorizes the disclosure and/or use of health information about you. Failure to provide all the information requested may invalidate this Authorization.

EXPLANATION

This authorization is being requested of you to comply with the terms of the Confidentiality of the Medical Information Act of 1981, Civil Code Section 56 et seq. and the Health Insurance Portability and Accountability Act (HIPAA) of 2003.

Name of Patient:	
Date of Birth:	**Phone #**

USE AND DISCLOSURE OF HEALTH INFORMATION

I hereby Authorize: Orthopaedic Specialists of North County	
Address: 3905 Waring Road	Phone: 760-724-9000
City: Oceanside State: CA Zip::92056	FAX: 760-724-3686

To release my records to:

Name/Facility:	Attention:
Address:	Phone:
City: State: Zip:	FAX:
EMAIL ADDRESS:	

INFORMATION TO BE RELEASED

☒ **Pertinent Information (This is what most physicians need):** Progress Notes, Labs, Xray/MRI/CT and OP Reports.
☐ Xray **FILMS** ☐ Billing ☐ Physical Therapy
OR ☐ other – please be specific_____

The Date of Service I am requesting is from_____TO_____
***If not date is entered only 6 months will be released.

AUTHORIZATION TO RELEASE STATUTORILY PROTERCTED INFORMATION

I specifically authorize release of the following information (check and initial as appropriate):

☐ Mental health treatment information	Patient	Provider Print and Sign Name
☐ Psychiatric progress note	Initial:	
☐ Therapy notes	Initial:	
☐ Labs	Initial:	
☐ HIV test results	Initial:	
☐ Alcohol/drug treatment information	Initial:	

PURPOSE OF REQUESTED USE OR DISCLOSURE

Purpose of requested use or disclosure:

☒ Patient Request ☐ Continuing Care ☐ Legal

AUTHORIZATION FOR USE FOR DISCLOSURE OF HEALTH INFORMATION

☐ **Insurance** ☐ **Other**_____

EXPIRATION

This Authorization expires [insert date]:_____

If no date is given; this authorization will expire 30 days from the signature date.

MY RIGHTS

I may refuse to sign this Authorization. If I refuse to sign this Authorization, I should know that by law, my health information cannot be released. My refusal will not affect my ability to obtain treatment or payment or eligibility for benefits.
I may inspect or obtain a copy of the health information that I am being asked to allow the use or disclosure of.

I may revoke this authorization at any time, but I must do so in writing and submit it to the- following address:·

Orthopaedic Specialist of North County
3905 Waring Rd
Oceanside, Ca 92056

My revocation will take effect upon receipt, except to the extent that others have acted in reliance upon this Authorization.
I have a right to receive a copy of this Authorization.

☐ Yes	☐ No	Initial:	Date:

Information disclosed pursuant to this authorization· could be re-disclosed by the recipient. Such re-disclosure is in some cases not protected by California law and may no longer be protected by federal confidentiality law {HIPAA).

SIGNATURE

Patient Signature:	Date:
Legal Representative Signature: Patient representative/spouse/financial responsible party	Date:
If signed by someone other than the patient state your legal relationship to the patient and why you have the authority to act for the patient:	
Witness Signature:	Date:

Please check one: ☐ **MAIL** ☐ **FAX** ☐ **PICKUP** ☐ **EMAIL**

**********OFFICE USE ONLY**********

Distribution ☐ mail ☐ Pick up or ☐ Other Completed by:_____Date:_____