MEDICAL RELEASE AUTHORIZATION OF HEALTH INFORMATION

This form is used to authorize the release of protected health information in accordance with the Privacy Rule of the Health Insurance Portability and Accountability Act of 1996 (HIPPA).

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

Name of patient: _____ **Date of Birth**: _____

USE AND DISCLOSURE OF HEALTH INFORMATION

I hereby authorize: Orthopaedic Specialists of Massachusetts
825 Washington Street, Suite 260
Norwood, MA 02062
P 781-769-6720 F 781-769-0691

To release the following information:

- ¨ Entire Record: _____
- ¨ Entire Record for specific body part: _____
- ¨ Office Note –Date(s) of Service: _____
- ¨ Lab Tests – Date(s) of Service: _____
- ¨ Radiology Reports – Date(s) of Service: _____
- ¨ Other (please specify needed information and date(s) of service: _____

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

- ¨ Mental health treatment information (A separate authorization is required to authorize the disclosure or use of psychotherapy notes).
- ¨ HIV test results
- ¨ Alcohol/drug treatment information
- ¨ Genetic information/testing

PURPOSE:
The purpose of the release of this information is:

Insurance or other third party reimbursement
Continuity of medical care
Pending legal action
At the request of patient
Other (Specify) _____

I hereby authorize Orthopaedic Specialists of Massachusetts to release the above records to the following representative. The representative has agreed to pay reasonable administrative fees made by our office to supply copies of such records.

_____ Phone: _____

Name of Representative (or SELF)

_____

Representative Capacity (e.g. attorney, records requestor, agent, etc.)

_____

Address: Street, City, State and Zip Code

I understand the following:

Patient's Initials

_____ The information in my medical record may include information relating to sexually transmitted disease, acquired immunodeficiency syndrome (AIDS), or human immunodeficiency virus (HIV). It may also include information about behavioral or mental health services and treatment for alcohol and drug abuse. I understand that by signing this authorization, I am authorizing the release of such information unless specified otherwise above.

_____ I realize that Orthopaedic Specialists of Massachusetts has a responsibility to maintain the confidentiality of the medical records in their possession. I understand that once this information is disclosed it may be re-disclosed by the recipient and the information may not be protected by federal privacy laws or regulations. Orthopaedic Specialists of Massachusetts will not be held responsible for any subsequent disclosure by the recipient of the health information. I release Orthopaedic Specialists of Massachusetts of any liability that may arise as a result of any subsequent disclosure of my health information by the recipient.

_____ This authorization remains valid for two years from the date of signature.

_____ My treatment or payment for my treatment cannot be conditioned on the signing of this authorization.

_____ Any facsimile, copy or photocopy of the authorization shall authorize you to release the records requested herein. This authorization shall be in force and effect until two years from the date of execution, and then will expire.

_____ I have a right to revoke this authorization in writing at any time, except to the extent information has been released in reliance upon this authorization.

_____ _____

Signature of Patient or Legally Authorized Representative Date

_____

Name and Relationship of Legally Authorized Representative to Patient