The Orthopedic Center
510 Idlewild Avenue Ste 200
Easton, MD 21601

AUTHORIZATION TO RELEASE PROTECTED HEALTH INFORMATION (PHI)

Patient Name: _____

Date of Birth: _____ Social Security #: _____

Provider in possession of PHI:
Address: **THE ORTHOPEDIC CENTER**
510 Idlewild Avenue
Ste 200
Easton, MD 21601

Individual or Entity To Whom
the PHI is to be Released: Name: _____
Address: _____
_____
_____

Description of PHI to be Used, Disclosed, or Released (check all that apply):

☐ My demographic information. (Check all that apply)

__ Name __ Street Address __ City/State/Zip __ Home Telephone
__ Birthdate __ Age __ Gender __ Business Telephone
__ Race __ Ethnicity

☐ My billing and/or insurance information.
__ Billing information
__ Insurance information

☐ Medical data/information relating to:
__ Visits/Encounters/Dates of Service between _____ and _____.
Date *Date*
__ Medical conditions, including: _____
__ Procedures relating to: _____
__ Specially protected health information:
__ Psychotherapy notes
__ Mental health information
__ HIV/AIDS information
__ Substance Abuse Treatment Records
__ Other: _____

☐ My entire medical record (please provide the reason your entire medical record is necessary)
_____

This Authorization is given for the sole purpose of: _____
(Reason for Use, Disclosure, or Release)

This Authorization will expire: _____
(Specific expiration date or timeframe for expiration, not to exceed more than 1 (one) year.)

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Disclosure Request of Protected Health Information (PHI) for Third Parties (Family Members)

I authorize THE ORTHOPEDIC CENTER to disclose medical and/ or financial information to the following individual(s):

1.) _____ Date of birth _____ Relationship _____

2.) _____ Date of birth _____ Relationship _____

Date of birth used for verifying purposes only

Please be advised this authorization is only valid for a MAX of 1 (one) year, unless you specify a shorter amount of time. If less than 1 year authorization for PHI, please specify in the space provided: _____

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As the person signing this Authorization, I understand that I am giving my permission to and authorizing the above-named Provider or other third party to release my confidential health information.

Neither The Orthopedic Center nor the recipient of my records has conditioned my treatment, payment, enrollment or eligibility for benefits on my signing this Authorization.

I understand I have the right to revoke this Authorization at any time, but my revocation is not effective until delivered in writing to the individual or entity in possession of my records. The individual or entity in possession of my records may have acted on my original Authorization in good faith before receiving my revocation.

I further understand The Orthopedic Center is not responsible for any disclosures of my health information that may occur from the recipient of my records once The Orthopedic Center provides my confidential health information in response to this Authorization.

_____ _____

(Date) *(Patient's signature)*

OR

_____

(Signature of patient's representative)

_____

(Relationship to patient)

OFFICE USE ONLY: EMR note entered by: _____ Date: _____