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Top Orthopedic Experts Dedicated to Summit County

HIPPA RELEASE AUTHORIZATION

Pursuant to 45 CFR 164.508

AUTHORIZATION TO USE AND DISCLOSE PROTECTED HEALTH INFORMATION

Patient Name: _____ Date of Birth: _____
SSN: _____ Address: _____
City: _____ State: _____ Zip: _____ Phone: _____

RELEASE RECORDS TO: (Please allow 5 – 7 business days to complete)
[ ] Patient/Patient's Authorized Representative (fee may apply) [ ] Attorney (fee may apply)
[ ] Healthcare Facility/Physician [ ] Other

Name: _____
Address: _____ City: _____
State: _____ Zip: _____ Phone: _____ Fax: _____

I authorize Panorama Summit Orthopedics to release the records indicated below to the individual/entity noted in this authorization (Check all that apply):
Date(s) of Service Requested: _____ Thru: _____ Expiration Date: _____
[ ] Medical Records only [ ] X-ray Films only [ ] Both Medical Records and X-ray Films
[ ] Billing Records [ ] Physical Therapy notes [ ] Other _____

REVOCATION: I understand I may revoke this authorization at any time in writing. Cancellation of this authorization does not apply to any records previously released in reliance of this authorization. For records to be release directly to the patient, an expiration date of "NONE" is acceptable. For all others, the maximum period for release of records without an updated authorization is one year. A copy of this form is as valid as the original.

I understand that once my information is released under this authorization, my physician(s) and their employees cannot prevent the re-disclosure of that information.

AUTHORIZATION: I authorize Panorama Summit Orthopedics to release the information marked above to the designated recipient(s).

_____ _____
Signature of Patient/Guardian Relationship to Patient

_____ _____
Today's Date Reason Patient Unable to Sign

PANORAMA
SUMMIT ORTHOPEDICS

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