ORTHOPAEDIC SPINE INSTITUTE RELEASE OF MEDICAL RECORDS

AUTHORIZATION FOR RELEASE OF PROTECTED HEALTH INFORMATION

Patient Name _____ Date of Birth: ____/____/_____

I request that my protected health information (PHI) ***be disclosed to / obtained from*** (circle one):
Recipient Name:_____
Address: _____ City:_____ State: _____ Zip: _____
E-Mail:_____Fax : _____

I authorize the following PHI to be released from my medical record(s):
_____ All Records Pertinent to Care at Orthopaedic Spine Institute
_____ Records Covering Period of Time from _____ to _____
_____ Records Regarding Treatment of Specific Illness, Condition, or Injury (please specify)_____
_____ Other (please specify) _____

I understand that the information in my health record may include information relating to sexually transmitted disease (STD), acquired immunodeficiency syndrome (AIDS), or human immunodeficiency virus (HIV). It may also include information about behavioral or mental health services, and treatment of alcohol or drug abuse. State and federal law protect the following information.

If this information applies to you, please indicate if you would like this information released or obtained (include dates where appropriate):
Alcohol, Drug, or Substance Abuse Records Yes No Dates:_____

Purpose for requesting information:
Legal Insurance Personal Continuation of Care Other (please specify other on line below):
_____

Disclosure Format (Paper is default if not marked.):
US Mail Fax Secure E-Mail Patient Portal Other (please specify):_____

By signing this authorization form, I understand that:
• I am authorizing Orthopaedic Spine Institute to disclose/obtain certain protected health information (PHI) about me to the party or parties listed above.
• I certify that I have no knowledge of any action which would alter my rights to the aforementioned records.
• I have the right to change or cancel this authorization at any time by notifying the Privacy Officer, in writing at Orthopaedic Spine Institute SC 1585 N Barrington Rd, DOB2 Ste 506, Hoffman Estates, IL 60169.
Revocation will not apply to information that has already been disclosed in response to this authorization.
• I understand that unless otherwise revoked, this authorization will expire 1 year from the date signed.
• I understand that I do not have to sign this authorization and that Orthopaedic Spine Institute cannot condition treatment or payment on whether I sign this authorization.
• I understand that information used or disclosed based on this authorization may be subject to redisclosure by the recipient named above and may not be protected by federal laws and regulations regarding the privacy of my protected health information. I understand that I have the right to inspect and copy the information to be disclosed.
• I understand that Orthopaedic Spine Institute may receive reimbursement from the above recipient for the expense of supplies and labor necessary to disclose my personal health information.

_____ _____
Patient or Authorized Representative Signature Print Name

_____ _____
Witness Signature Signature Date

_____ _____
Relationship to Patient (if other than self) Witness Signature Date