BOSTON ORTHOPAEDIC & SPINE

AUTHORIZATION TO DISCLOSE MEDICAL RECORD INFORMATION

Patient Information

Patient's Name: _____Telephone #: _____

Patient's Address: _____ D. O. B.: _____

City: _____ State: _____ Zip: _____ Email: _____

Release Information To

Name: _____ Telephone #: _____

Address: _____ Fax #: _____

City: _____ State: _____ Zip: _____ Email: _____

How Would You Like To Receive This Information? (*please check off all that apply*)

◯ Mail ◯ Fax ◯ Email ◯ Pick Up (*please specify office location:* _____)

Purpose Of Request

◯ Personal ◯ Legal Matter ◯ Other (please specify: _____)

Information To Be Released (*please check off all that apply & specify dates*)

◯ Office Visits _____ to _____ ◯ Operative Notes _____ to _____

◯ Billing: _____ to _____ ◯ Imaging Reports _____ to _____

◯ Other: _____ to _____ ◯ Complete Medical Record

◯ X-ray Images _____to _____ *(specify how you would like to receive your x-rays: ◯Email ◯ Mail)*

Protected Under State Law (*must be checked off to have information released*)

◯ Alcohol/Drug Abuse ◯ Psychotherapy Notes ◯ HIV/AIDS ◯ Genetic Testing

I Understand and Agree that:

- I have signed this Authorization voluntarily, and these records are released at my request. Except to the extent allowed by law, Boston Orthopaedic & Spine, LLC. will not condition treatment on my signing this Authorization.
- I may revoke this Authorization in writing at any time except to the extent that action has been taken in reliance on it. To revoke this Authorization, a written request must be submitted to the Compliance Officer at 20 Guest St, Suite 225, Brighton, MA 02135.
- Any disclosure carries the potential for un-authorized re-disclosure and therefore may no longer be protected by state or federal privacy laws. I further understand that Protected Health Information which is emailed may or may not be encrypted. I release Boston Orthopaedic & Spine, LLC from any legal liability that may arise from the disclosure or re-disclosure of this information.
- If Boston Orthopaedic & Spine, LLC maintains any of my records from outside providers, these will not be released unless I specifically ask for them under "Other" in the "Information To Be Released" section. Please include entity name, provider, and specific dates if known.
- This authorization will automatically expire **1 year from the date signed** unless otherwise specified: _____/_____/_____.
- I have read and understand the above statements and authorize the disclosure of the information requested above.

X_____ _____ _____ _____

Patient or Authorized Representative's Signature *Print Name* *Relationship to Patient* *Date*

This authorization must be completed in its entirety or it will not be processed.