AUTHORIZATION FOR RELEASE OF MEDICAL INFORMATION

Patient Name: _____ **Date of Birth:** _____

Alias/Maiden Name(s): _____ **Phone:** _____

Type of information to disclose:

- ☐ All Medical Records 2 years prior from last date seen
- ☐ All Medical Records from (date to date) _____
- ☐ Imaging/X-ray CD
  * Please note: A $5.00 fee per set of imaging will apply.
- ☐ Other (please specify) _____

RESTRICTIONS: Only medical records originated through **Southwest Shoulder Elbow & Hand Center** will be copied. This authorization is valid only for the release of medical information dated prior to and including the date on this authorization unless other dates are specified.

This information may be disclosed and used by the following individual or organization:

Release To: _____

Address: _____

City, State, Zip: _____

Fax: _____ **Phone:** _____

Delivery of Records: ☐ Pick Up ☐ Please mail records ☐ Please fax records.

The purpose of disclosure: ☐ FMLA/Disability ☐ Continuing Care ☐ Other (please specify) _____

I understand I may revoke this authorization at any time. I understand that if I revoke this authorization I must do so in writing and present my written revocation to the medical records department. I understand that the revocation will not apply to information that has already been released in response to this authorization. I understand that the revocation will not apply to my insurance company when the law provides my insurer with the right to contest a claim under my policy. Unless I revoke this authorization earlier it will expire 1 year from date of signature.

I understand that authorizing the disclosure of this health information is voluntary. I understand that any disclosure of information to a third party, the information may not be protected by federal confidentiality rules and may be re-disclosed by the person or organization that receives the information.

I release Southwest Shoulder Elbow & Hand Center PC, its employees and agents, from any legal responsibility or liability for the disclosure of the above information to the extent indicated and authorized herein. I have read the above foregoing Authorization for Release of Medical Information and do hereby acknowledge that I am familiar with and fully understand the terms and conditions of this authorization.

X_____ _____

Patient or Authorized Representative Signature **Date**

(Guardian or Authorized Representative must attach documentation of such status.)

_____ _____

Printed Name of Patient or Authorized Representative Relationship to Patient