

**AUTHORIZATION TO DISCLOSE PROTECTED HEALTH INFORMATION**

IN ORDER FOR THIS AUTHORIZATION TO BE VALID ALL BLANKS MUST BE COMPLETED

I, (PATIENT NAME) \_\_\_\_\_ SSN: \_\_\_\_\_ and born \_\_\_\_\_, \_\_\_\_\_, hereby authorize and consent to allow HAND AND RECONSTRUCTIVE SURGEONS, INC. to disclose information contained in, provide access to, or provide such photocopies as may be requested of my Protected Health/Billing Information to the person or organization listed below:

PERSON(S): \_\_\_\_\_ COMPANY: \_\_\_\_\_

ADDRESS: \_\_\_\_\_ CITY/STATE/ZIP: \_\_\_\_\_

The purpose or need for this release of information is:

\_\_\_\_\_

The specific information to be used or disclosed is:

- ENTIRE CHART
  - TREATMENT OR EXAMINATION RENDERED DURING THE PERIOD FROM \_\_\_\_\_ TO \_\_\_\_\_
  - FACE SHEET
  - HISTORY & PHYSICAL
  - DISCHARGE SUMMARY
  - CONSULTATIONS
  - OTHER
  - LABORATORY REPORTS
  - X-RAY REPORTS
  - X-RAY FILMS
  - PATHOLOGY
  - PROGRESS NOTES
  - PHYSICIANS' ORDERS
  - NURSES' NOTES
  - OPERATIVE REPORT
  - HEART CATH
  - DETAIL BILLING
  - ER RECORDS
- PLEASE SPECIFY: \_\_\_\_\_

I hereby release **covered entity** and its staff from all legal responsibility or liability, which may arise from the release of or reproduction of such Protected Health/Billing Information to the recipient. I understand my protected health information that is used or disclosed by this authorization may be subject to redisclosure by the recipient, and the law will no longer protect the privacy of my Protected Health Information. I understand that Hand and Reconstructive Surgeons, Inc. is entitled to request and receive reasonable fees for providing such photocopies of my medical record(s) as may be requested as a condition precedent to their release.

I understand that this consent is subject to written revocation by me at any time except in those circumstances in which **Covered entity** or its staff has taken action in reliance on it. A revocation should be sent to Hand and Reconstructive Surgeons, Inc. 6601 Centerville Business Parkway, Suite 202, Centerville, OH 45459. Without such written express revocation, this consent will expire on the following date: \_\_\_\_\_. If a date is not specified, this consent will expire 1 (one) year from the date of signature.

The patient must sign authorization. If the patient is a minor or is an incompetent adult, their guardian must sign authorization. If there is no guardian appointed by the Court, the authorization must be signed by the nearest relative. If the patient is unable to sign this authorization, please state the reason: \_\_\_\_\_

**THIS CONSENT AND AUTHORIZATION MAY INCLUDE, BUT IS NOT LIMITED TO THE RELEASE OF PSYCHOLOGICAL, PSYCHIATRIC, ALCOHOL, DRUG ABUSE AND HIV/AIDS INFORMATION.**

Signature of Patient or Representative \_\_\_\_\_

Date Signed \_\_\_\_\_

Relationship (If other than Patient) \_\_\_\_\_

Address \_\_\_\_\_

City, State \_\_\_\_\_

Witness Signature & Date Signed \_\_\_\_\_