OAD Physician:_________________________________ Date Requested: _____________

AUTHORIZATION TO RELEASE INFORMATION

Section A: Must be completed for all authorizations

I hereby authorize the use or disclosure of my individually identifiable health information as described below. I understand that this authorization is voluntary. I understand that if the organization authorized to receive the information is not a health plan or health care provider; the released information may no longer be protected by federal privacy regulations. This release form must be completely filled out in order to be processed.

Patient Name: _______________________________ Date of Birth:_________________

Social Security No.: ________________________

Phone Number___________________

Person/Organization providing info:

Orthopedic Associates of Dallas, LLP_________
Name

3900 Junius , Suite 500___________
Address

Dallas, TX 75246_______________________
City, State, Zip code

214-823-1644___________________________
Fax Number

Release information to:

____
Name

____
Address

____
City, State and Zip Code

____
Fax Number

I am requesting the following information to be released for dates of service _____/_____/_____ to _____/_____/_____:
(Date of service must be entered to release any information)

- ☐ History Physical
- ☐ Discharge Summary
- ☐ Psychiatric Evaluation/Testing
- ☐ Physician Notes
- ☐ Physical Therapy Records
- ☐ X-ray films – including CT, MRI, Bone Scan, etc.
- ☐ OTHER (specify ___________________________________)
- ☐ Correspondence
- ☐ Medication Sheets/Prescriptions
- ☐ Patient Information Sheets
- ☐ Labs
- ☐ Therapist/Nurses Notes
- ☐ Test Results (including CT scan, MRI results)

I am requesting these records be released for the following reason: ☐ Personal Use ☐ Legal Reasons ☐ Insurance ☐ other ☐ Physician's Office (Dr. appt)

Section B: Must be completed only if a health plan or health care provider has requested the authorization

The health plan or health care provider must complete the following:

* Will the health plan or care provider requesting the authorization receive financial or in-kind compensation in exchange for using or disclosing the health information described?_____________Yes ____________ No

The patient or the patient's representative must read and initial the following statements:

* I understand that my health care and the payment for my health care will not be affected if I do not sign this form.
* I understand that I may see and copy the information described on this form if I ask for it, and that I get a copy of this form after I sign it. Further, I understand there may be a fee for copy of this information.

Section C: Must be completed for all authorizations

The patient or the patient's representative must read and initial the following statements:

* What is the purpose of the use or disclosure?:____

* I understand that this authorization will expire 90 days from the date of my signature.

* I understand that I may revoke this authorization at any time by notifying the providing organization in writing, but if I do it won't have any affect on any actions they took before they received the revocation.

* I understand there will be a fee for copying and releasing my records, and that such fee is in accordance with state and federal guidelines.

* I understand that my records are protected under state and federal law. I understand that specific information to be disclosed may include history of drug or alcohol abuse, mental health treatment, AIDS or any other medical information.

____ ______________

Signature of patient or patient's representative
(form must be completed prior to signing)

Date

Printed name or patient's representative:____________________________________Relationship to Patient:_____________
____