PACIFIC ORTHOPAEDIC ASSOCIATES

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Authorization for release of protected health information

Patient Information

Last Name	First Name	Middle Initial	Date of birth
Address			
City	State	Zip Code	
Home Phone		Work Phone	
Date of Request		**Date Needed**	

Authorization

❒ I authorize Pacific Orthopaedic Associates to **release** information to:

Name of provider or facility:

Address:

City: State: Zip Code:

❒ This request only ❒ One year from the date of this authorization

Purpose of this request

Check one box only

❒ Healthcare ❒ Insurance Coverage ❒ Legal ❒ Personal ❒ Other:

Type of records requested

Check one box only

❒ Progress Notes ❒ Diagnostic Reports ❒ All Information ❒ Other: (please describe)

❒ All medical records related to a specific illness or injury

Specific Injury or Illness: Date(s) of treatment:

Method of delivering information

❒ **I will pick up the records at the Medical Records Department**

❒ **Please mail the records to me at**

Statement to release protected health information

I understand that:

- I may cancel this authorization at any time by submitting a **written** request to Pacific Orthopaedic Associates, except to the extent that action has already been taken.
- Release of HIV-related information, mental health related care, or substance abuse diagnosis and treatment information requires additional authorization.
- If the person or facility receiving this information is not a health care or medical insurance provider covered by privacy regulations, the information stated above could be redisclosed.
- I understand that a reasonable fee may be charged for duplication of records. An estimate of those charges will be provided upon request prior to duplication.

Signature of patient or representative Date

If not the patient, please indicate below:

❒ Parent or Guardian of minor patient ❒ Guardian or conservator of incompetent patient ❒ Beneficiary or personal representative of deceased patient

For Internal Use Only DATE RECEIVED: DATE PROCESSED: INITIALS: