MEDICAL RECORDS RELEASE FORM 2023

Medical release forms are used to request that Dominion Ortho & Spine share a patient's medical history with a third party (employer, insurance company, school, etc.). A verbal release agreement is not sufficient; therefore, these requests must be made in writing.

PATIENT LAST, FIRST, MIDDLE INITIAL:

PATIENT DATE OF BIRTH:

LAST FOUR DIGITS OF PATIENT SOCIAL SECURITY NUMBER:

PATIENT STREET ADDRESS:

PATIENT CITY, STATE AND ZIP CODE:

PATIENT PHONE NUMBER:

PATIENT EMAIL ADDRESS

WHO IS REQUESTING MEDICAL RECORDS

REQUESTOR'S FULL ADDRESS

REQUESTOR'S PHONE

REQUESTOR'S FAX

PLEASE DISCLOSE MY CHART NOTES TO THE REQUESTOR LISTED ABOVE
YESNO

PLEASE DISCLOSE MY LABS/PATHOLOGY TO THE REQUESTOR LISTED ABOVE
YESNO

PLEASE DISCLOSE MY X-RAY DIAGNOSTICS TO THE REQUESTOR LISTED ABOVE
YESNO

PLEASE DISCLOSE MY PATIENT VISIT SUMMARY/ENCOUNTERNOTES TO THE REQUESTOR LISTED ABOVE
YESNO

PLEASE DISCLOSE MY MOST RECENT VISIT NOTES TO THE REQUESTOR LISTED ABOVE
YESNO

PLEASE DISCLOSE MY BILL/SUPERBILL/INVOICE TO THE REQUESTOR LISTED ABOVE
YESNO

PLEASE DISCLOSE MY ALL RECORDS TO THE REQUESTOR LISTED ABOVE

I REQUEST THAT THE ABOVE MEDICAL RECORDS BE SENT TO THE REQUESTOR VIA:
☐Mail
☐Pick-Up
☐FAX/Email

PROVIDE EMAIL OR FAX OF REQUESTOR

REASON FOR REQUEST:
☐Patient Request

☐Treatment, Payment, Operations
☐Other _____

THIS AUTHORIZED REQUEST WILL EXPIRE (ENTER DATE BELOW)

I understand that if the person or entity that receives the information is not a health care provider or health plan covered by federal privacy regulations, the information described above may be re-disclosed and no longer protected by those regulation.

I understand that I may refuse to sign this authorization and that my refusal to sign will not affect my consent to the use or disclosure of my protected health information for purposes of treatment, payment, or healthcare operations.

I may inspect or copy any information used / disclosed under this authorization. I have authorized Dominion Orthopaedic & Spine to photocopy this authorization, and you may accept a photocopy of this authorization as if it were the original.

I understand that I may revoke this authorization in writing at any time to Dominion Orthopaedic & Spine, except to the extent that the information has already been released in response to this authorization.

Unless otherwise revoked, this authorization will expire in 12 months unless otherwise dated above.

I UNDERSTAND THAT SENSITIVE PROTECTED HEALTH INFORMATION TO BE RELEASED MAY INCLUDE INFORMATION THAT IS RELATED TO SEXUALLY TRANSMITTED DISEASE, ACQUIRED IMMUNODEFICIENCY SYNDROME (AIDS), OR HUMAN IMMUNODEFICIENCY VIRUS (HIV), BEHAVIORAL OR MENTAL HEALTH SERVICES, AND / TREATMENT FOR ALCOHOL AND / OR DRUG ABUSE.

MY SIGNATURE BELOW AUTHORIZES THE RELEASE OF ALL SUCH INFORMATION, UNLESS I HAVE SPECIFICALLYMARKED NO BELOW.

I CONSENT TO THE DISCLOSURE OF MY SENSITIVE PROTECTED HEALTH INFORMATION WHICH MAY INCLUDE:

Patient Signature: _____

Patient Representative: _____

Date: _____