BONE & JOINT

Completion of Authorization for Release of Medical Information

The Authorization for Release of Medical Information is a two-sided form. All sections MUST be filled out for the form to be valid.

1. **Patient Information** – ALL FIELDS must be completed. Full name, full address, birthday, and phone number MUST be provided.

2. **Released Information From -** This is for designating who should RELEASE medical records.
   a. To have **only** Bone & Joint Clinic records released – Check Box 1
   b. To have **only** Bone & Joint Surgery Center records released – Check Box 2
   c. To have **both** Clinic and Surgery Center records released – Check Box 1 & 2
   d. For us to request records from another facility/provider – Check Box 3 (Other)
   e. If "Other" is checked, fill in the following information below that box:
      i. Name (e.g. other health facility, another physician, insurance company, etc.)
      ii. Mailing Address
      iii. City, State, Zip Code
      iv. Phone No.
      v. Fax No. (If known)

3. **Released Information To -** This is for designating the individual or facility that the medical records will be going to.
   a. To release records to yourself, check the box labeled "self".
   b. If releasing to someone other than yourself, please complete all fields in the boxes below:
      i. Name
      ii. Mailing Address
      iii. City, State, Zip Code
      iv. Phone No.
      v. Fax No. (if known)

4. **For the Following Dates of Service** – Please do not leave this section blank. Please be as specific as possible regarding the dates of service on the records &/or images you are requesting**.**

5. **Information to Be Released** – Please do not leave this section blank. Check only those specific records that you wish to receive or have released. If the information to be released does not fit into any of the designated categories, please specify your request in the "**OTHER**" section.

6. **Disclosures Requiring Special Consent** – **MUST BE INITIALED IF YOU ARE ALLOWING RELEASE OF THESE RECORDS.** (Drug/Alcohol Abuse/Treatment; Mental/Behavioral Health Records; HIV Test Results)

7. **Release Method** – How are the records to be released?

    a. **Mail**: records will be mailed to the address specified in #3
    b. **Fax**: records will be faxed to fax # specified in #3
    c. **Pick up**: Specify the Bone & Joint location records will be picked up at to avoid delays in processing
    d. **Image requests**: Specify how imaging is to be released.
        i. Paper
        ii. CD/DVD

8. **Purpose or Need for Release of Records** – Please check only those boxes that apply.

9. **Expiration** – This authorization is good for 1 year from the date it is signed, unless a specific date is given. Please note: if the current date is put in this space, the form will expire that day.

10. **Signature of Patient OR Person Legally Authorized to Sign for Patient** – RELEASE FORM MUST BE SIGNED

    Date – The current date should be entered when signing.

    Print Name of Person Signing Above – Release forms must have printed name of the person signing.

11. **If the form is signed by a person other than patient, please check reason AND authority to do so**. Boxes must be checked for both "**Patient is**" field and "**Legal Authority**" field. Please also be sure to furnish any applicable legal paperwork (POA, Death Certificate, etc.), if not already on file.

12. **For Organization Use Only** – **Completed by Bone & Joint Staff**