Litchfield Hills
Orthopedic Associates, LLP

SPECIALIZED CARE YOU CAN TRUST

www.LHOA.com

AUTHORIZATION FOR DISCLOSURE OF PROTECTED HEALTH INFORMATION

PATIENT INFORMATION (Please fill out all fields in this section.)

Last Name: ______________________ First Name: ______________________

Date of Birth: ____

Address: ____

City: __________________ State: ______ Zip: ________ Phone: ______________

WHAT YOU AUTHORIZE US TO RELEASE (Please check all appropriate boxes.)

❒ Entire Record ❒ Workers' Comp Records Only ❒ Office Notes ❒ Operative Reports ❒ Test Results

❒ LHOA Therapy ❒ Radiology Films—**There is a charge to copy films of $10.00/film.*

❒ Other: ____

WHAT YOU DO NOT AUTHORIZE US TO RELEASE (Please check all appropriate boxes.)

❒ Mental Health Records ❒ HIV & AIDS Records ❒ Alcohol/Drug Abuse Records

❒ Other: ____

DATE OR DATE RANGE OF SERVICE YOU ARE AUTHORIZING US TO RELEASE

Specific Dates of Service: ____, OR

Records From: (month/year) __________________ To: (month/year) __________________

WHO DO YOU AUTHORIZE US TO RELEASE (MAIL) YOUR RECORDS TO:

❒ Myself

❒ Other Party—Name: ____

Address: ______________________ City: ______________ State: ____ Zip: ________

DELIVERY METHOD (Complete only if records are being released directly to you. If you do not choose a delivery method, your records will be mailed to you.)

❒ Electronic ❒ Paper Copy

For Office Use Only:

If records are released electronically, specify how records were released: ____________ Initials: ______

WHO MAY PICK UP MY RECORDS (Please complete this section if you authorize someone other than yourself to pick up your medical records. NOTE: The person you authorize will need to bring a photo ID.)

Last Name: ___________________________________ First Name: __________________________________

DOB: ________________________ Relationship to You: ____

PLEASE CHECK THE BOX BELOW TO ACKNOWLEDGE YOU ARE AWARE OF OUR FEE FOR MEDICAL RECORDS

❒ I am aware that there will be a charge of up to 65 cents/page for my medical records.

EXPIRATION DATE

This authorization is valid for six months unless you specify an expiration date here: ___________________

YOUR RIGHTS WITH RESPECT TO THIS AUTHORIZATION:

Right to Receive Copy of This Authorization—I understand that if I sign this authorization, upon request, I will be provided with a copy of this authorization. Right to Refuse to Sign This Authorization—I understand that I am under no obligation to sign this form and that LHOA may not condition treatment, payment, enrollment in a health plan, or eligibility for health care benefits on my decision to sign this authorization. Right to Withdraw This Authorization—I understand that I have the right to withdraw this authorization at any time by providing a written statement of withdrawal to the Privacy Officer. I am aware that my withdrawal will not be effective regarding the uses and/or disclosures of my health information that LHOA made prior to receipt of my withdrawal statement. Right to Inspect or Copy the Health Information to Be Used or Disclosed—I understand that I have the right to inspect or copy (may be provided at a reasonable fee) the health information I have authorized to be used or disclosed by this authorization form. I may arrange to inspect my health information or obtain copies of my health information by the Medical Records Department.

Signature: ____________________________________ **Date Signed:** ______________________________

(Patient or Legal Representative)

Printed Name of Person Signing (if not patient): ____

Relationship to Patient: ____

NOTICE TO RECIPIENTS:

As the recipient of this information, you may use this information only for the stated purpose. You may disclose this information to another party ONLY: *with written authorization from the patient or his or her legal representative; *as required or authorized by state and/or federal law; or *if urgently needed for the patient's continued care. Your signature above indicates that you understand if the organization authorized to receive the information is not a healthcare provider or health plan, and the information disclosed is NOT protected by the federal guidelines for HIV, AIDS, drug and alcohol, or psychiatric information, then the released information may no longer be protected by the HIPAA Federal Privacy Regulations.

Litchfield Hills Orthopedic Associates, LLP, complies with applicable Federal civil rights laws and does not discriminate on the basis of race, color, national origin, age, disability, or sex.