

Orthopedic Services Company, LLP

1380 Lusitana Street, Suite 608 • Honolulu, HI 96813 • Phone: (808) 536-2261 • Fax: (808) 536-3957

AUTHORIZATION FOR USE AND DISCLOSURE OF MEDICAL INFORMATION

I authorize * _____ to release the protected health information of:

*Patient Name: _____ Date of Birth: _____

Phone #: _____

TO: _____ (Name of Institution)
_____ (Address)
_____ (City, State, Zip Code)

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| <p>*Information to be disclosed:</p> <p><input type="checkbox"/> All medical records <input type="checkbox"/> Lab/Imaging Reports <input type="checkbox"/> Clinical notes <input type="checkbox"/> X-ray Film(s) <input type="checkbox"/> HIV test results specify () Yes () No <input type="checkbox"/> Restrict to the following dates/conditions: _____ _____ <input type="checkbox"/> Restrict to information necessary to complete form provided <input type="checkbox"/> Other (specify) _____ _____</p> | <p>*Purposes for Use and/or Disclosure: (check as many as apply)</p> <p><input type="checkbox"/> At the request of the individual <input type="checkbox"/> Legal Purposes <input type="checkbox"/> Insurance <input type="checkbox"/> Physician follow-up <input type="checkbox"/> Other _____ _____</p> |
|--|---|

_____ (initial) I agree to the release of the following information should it be contained in my medical record: **Acquired Immune Deficiency Syndrome (AIDS) or HIV, Alcohol and/or drug abuse treatment, or behavioral or mental health services. (If I do not specifically agree, this information will not be disclosed.)**

***Unless otherwise revoked, this authorization will expire on the following date or event: _____ .
If a date or event is not specified, this authorization will expire one year from my date of signature below.**

This authorization is voluntary. I understand that I can refuse to sign this authorization and that my refusal to sign will not affect my ability to obtain treatment from Orthopedic Services Company, LLP, nor will it affect my eligibility for benefits.

I understand that I have a right to revoke this authorization at any time. My revocation must be in writing (e.g., a letter) addressed to Orthopedic Services Company, LLP. I am aware that my revocation is not effective to the extent that the persons I have authorized to use and/or disclose my protected health information have acted in reliance upon this authorization.

I understand that the health information released under this authorization may be re-disclosed by the recipient and may no longer be protected under federal privacy regulations.

I understand that I have a right to inspect and copy my own protected health information to be used or disclosed in accordance with the requirements of the federal privacy protection regulations.

I hereby release Orthopedic Services Company, LLP from all liability and all claims of any nature whatsoever pertaining to disclosure of information, or of any professional opinions, findings, or recommendations as contained in the records released to or by Orthopedic Services Company, LLP. I certify that I have received a signed copy of this authorization.

*Requestor _____ SIGNATURE * _____ PRINT NAME

*Relationship: _____ (RELATIONSHIP TO PATIENT)(COMPLETE ONLY IF REQUESTOR IS NOT PATIENT) * _____ DATE

***Items that MUST be completed for authorization to be valid**