OrthoSC
THE STRENGTH OF EXPERIENCE

Phone: (843) 353-3460
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AUTHORIZATION FOR RELEASE OF PROTECTED HEALTH INFORMATION (PHI)

Section A: This section must be completed for all Authorizations					
Patient Name:			**Birth Date:** **Phone No.:**		
Person or Organization Authorized to Release the Protected Health Information:			**Person or Organization Authorized to Receive Protected Health Information:**		
Address:			**Address:**		
City:	**State:**	**Zip:**	**City:**	**State:**	**Zip:**
Phone #:_____ Fax #:_____			Phone #:_____ Fax #:_____		
Email address: ***(If requesting records/images via email)*****:**					
Purpose of the information (Reason for disclosure):					

Description of information to be disclosed

I understand there may be a charge for the retrieval and/or processing of my request. Processing time is 7-10 business days.

Description:	Date or Range Requested:	Delivery Options:
☐ All PHI in medical record ☐ Office Notes ☐ Operative Report ☐ Therapy Visit Notes ☐ MRI Report ☐ Radiology Images(X-ray/MRI) ☐ Billing ☐ Other: _____	☐ 1 year (Visit Notes, Labs & Procedures) ☐ 2 years(Visit Notes, Labs & Procedures) ☐ All Dates ☐ Range: _____ to _____ ☐ Other:_____	☐ Mail ☐ Fax: _____ ☐ Email: (Please ensure address is legible)

I acknowledge, and hereby consent to such, that the released information may contain alcohol, drug abuse, psychiatric, HIV testing, HIV results or AIDS information. _____ (Initial)

I understand that:

1. I may refuse to sign this authorization and that it is strictly voluntary.
2. I may revoke this authorization at any time in writing, but if I do, it will not have any affect on any actions taken prior to receiving the revocation. Further details may be found in the Notice of Privacy Practices.
3. If the requester or receiver is not a health plan or health care provider, the released information may no longer be protected by federal privacy regulations and may be re-disclosed.
4. I understand that I may see and obtain a copy the information described on this form, for a reasonable copy fee, if I ask for it.
5. If requested, I may receive a copy of this form after I sign it.

Section B: Signatures

I have read the above and authorize the disclosure of the protected health information as stated.
This authorization will expire in **90 days** unless otherwise specified below.

Patient's Signature:	**Date:**
Parent/Guardian/Representative's Signature:	**Date:**