AUTHORIZATION FOR ACCESS/RELEASE/DISCLOSURE OF HEALTH INFORMATION

Patient Name: _____ Chart ID:_____

Date of Birth: _____ Phone No.: _____

Home Address: _____

1. TYPE OF ACCESS/RELEASE/DISCLOSURE: I hereby authorize **Edison-Metuchen Orthpaedic Group** to provide:

☐ Access to review Health Information ☐ Photocopies of my Health Information, as requested below:

2. DATES/DESCRIPTION OF INFORMATION TO BE RELEASED/DISCLOSED: *(Check ALL that apply)*

☐ Office Notes ☐ Operative Reports ☐ Pathology Reports

☐ History & Physical ☐ X-Rays Reports

☐ Progress Notes ☐ EKG/EEG Reports ☐ Other (Specify): _____

☐ Consultation Reports ☐ Lab Reports _____

☐ Entire Medical Records Date(s) of Service: _____

3. SPECIFIC CONFIDENTIAL INFORMATION AUTHORIZED FOR THIS RELEASE/DISCLOSURE:

By signing my initials, I understand that the information to be released/disclosed from my medical record may include information relating to sexually transmitted disease, acquired immunodeficiency syndrome (AIDS), or human immunodeficiency virus (HIV), genetic information and tuberculosis information. It may also include information about behavioral or mental health services, and treatment for alcohol and drug abuse.

Patient Initials: _____

4. RELEASE/DISCLOSURE OF INFORMATION TO: ☐ Myself ☐ To organization/individual

Organization: _____ Individual Name: _____

Address: _____

Phone No.: _____ ☐ Please mail ☐ Please prepare for pick-up

5. PURPOSE OF RELEASE/DISCLOSURE: I authorize **Edison-Metuchen Orthopaedic Group** to release/disclose my health information for the following specific purpose(s): ☐ Medical Care ☐ Insurance ☐ Personal ☐ Other:_____

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6. TERM/EXPIRATION: This signed authorization will expire in **6** months unless an earlier date is indicated by you below. Please list a date or event when this authorization will no longer be valid *(this date may not be more than 6 months in accordance with Edison-Metuchen Orthopaedic Group's policy).* This authorization will no longer be valid after: _____.

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7. I understand that I have a right to revoke this authorization at any time.
- I understand that if I revoke this authorization, I must do so in writing.
- I understand that revocation will not apply to information that has already been released/disclosed in response to this authorization.
- I understand that the revocation will not apply to my insurance company when the law provides my insurer with the right to contest a claim under my policy.
- I understand that authorizing the release/disclosure of this health information is voluntary.
- I understand that I may refuse to sign this authorization and that my refusal to sign will not affect my ability to obtain treatment.

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8. I understand that Edison-Metuchen Orthopaedic Group may deny this request under limited circumstances as provided under Federal and State law protecting the privacy of health information.

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9. I understand that the cost of copying medical records is $1.00 per page. I have to make payment in full before medical records are released.

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10. I hereby authorize the access/release/disclosure of my individually identifiable health information, as described above. I understand that the information I authorize a person or entity to receive may be re-disclosed and no longer protected by Federal privacy regulations. However, the recipient may be prohibited from disclosing substance abuse information under the Federal Substance Abuse Confidentiality Requirements.

Patient Signature: _____ Date: _____

If the patient is a minor or otherwise unable to sign this authorization then obtain the signature of the authorized representative/individual below.

Description of Authority: _____ Date: _____

Signature: _____ Date: _____

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