HIPAA AUTHORIZATION FOR RELEASE OF PATIENT RECORDS

Date: _____/_____/_____ This authorization expires: _____/_____/_____
(If no date is written in, this authorization expires one year after the date signed.)

Patient Information

Last Name	First Name	Middle Initial	Date of Birth

Street Address	City	State	Zip Code

Phone Number

I hereby authorize New Hampshire Orthopaedic Surgery, P.A. to release the following records (*check relevant boxes)*:

- ☐ My entire medical record
  or
- ☐ Records relating to the following injury/condition only: _____
- ☐ Office notes
- ☐ Radiology reports
- ☐ Operative notes
- ☐ Other records: _____

UNLESS MY INITIALS APPEAR BELOW, I specifically and voluntarily authorize New Hampshire Orthopaedic Surgery, P.A. to include in the release of records any information relating to the following issues, *if applicable.* My initials indicate I do not consent to the release of records relating to the following*:* (could take 30-60 days to process if any of the below are initialed)

_____ Mental health illness/diagnosis
_____ Alcohol/drug abuse/treatment
_____ HIV/AIDS test results/diagnosis
_____ Communicable diseases

Person or Organization to who the information is being released to:

Name	Organization

Street Address	City	State	Zip Code

Phone Number	Fax Number

The purpose of the release of my medical records is: (Note, patient may decline to specify purpose)
_____

- I understand that if the person or the entity that receives the information is not a health care provider or health plan covered by the federal privacy regulations, the information described above may be redisclosed and no longer protected by those regulations.
- I understand that there may be medical records from another doctor or another medical facility in my chart.
- I understand that I may refuse to sign this authorization and that my refusal to sign will not affect my ability to obtain treatment or payment or my eligibility for benefits.
- I understand that I may revoke this authorization in writing at any time by submitting a written notice of my revocation, except to the extent that action has been taken in reliance on this authorization.
- I have read and understood this authorization, and hereby release The Orthopedic Center from any and all legal liability arising from the release of records authorized by this authorization, or from any re-disclosure of the records.

_____
Signature of Patient (**By signing here you WILL BE CHARGED for your records. More info below**)

In accordance with our policy, if you are releasing records to yourself, they will be mailed to you and will arrive in 7-10 business days. Records will **NOT** be available for pickup in any of our offices.

Pursuant to New Hampshire State Law Chapter 332-1 Section 332-I:1 you will be charged $15.00 for the first 30 pages and $0.50 for each additional page, plus postage. If you have any questions regarding this policy please contact our office.