

Informed Consent

Medical Records Release

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AUTHORIZATION FOR RELEASE OF MEDICAL RECORDS

This form must be signed by the patient or person authorized by law.

Name:		
Address:		
City:	State:	_ Zip Code:
Date of Birth:	Social Security Number:	
Other names (if applicable):		
Transfer of original and du	uplicate records may be expedited by e	electronic means.
I, for all photocopying charg		se the records in <u>Exhibit A</u> . I agree to pay
These records should be	released to	
		[name
and address of recipient] f	for the following purpose(s):	
		y treatment from <u>.</u> I may e may be made before I take it back. I

understand that I may check and get copies of the information disclosed. I understand that these records may be protected by the Federal Health Insurance Portability and

Accountability Act ("HIPAA"). I am aware the recipient may re-disclose these records. In such a case, they may no longer be protected by HIPAA. My records may be protected under state law. They cannot be disclosed without written consent. It can only be disclosed if it is provided for in the law and/or regulations.

This authorization will not be valid one year from the date below. My signature confirms that I have read, understood, and authorize the release of the information described in <u>Exhibit A</u>.

Name

Date/Time

Page 1 of 2

Patient Initials

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This form is for reference purposes only. It is a general guideline and not a statement of standard of care. Rather, this form should be edited and amended to reflect policy requirements of your practice site(s), CMS and Joint Commission requirements, if applicable, and legal requirements of your individual states. The ASPS does not certify that this form, or any modified version of this form, meets the requirements to obtain informed consent for this procedure in the jurisdiction of your practice.

EXHIBIT A

DETAILS OF HEALTH INFORMATION THAT CAN BE RELEASED

By placing a check mark in the space below, I permit the release of the following records from _____

- [insert dates]:
- _____to ____ ____ Complete medical records
- ____ All hospital/institution records (nursing records/progress notes)
- Hospital/institution records (surgical reports, history/physical exam reports, consultation reports, discharge summary)
- ____ Lab reports
- ____ Pathology reports
- ____ Imaging reports
- ____ EKG/cardiac reports
- ____ Physical/occupational therapy reports
- ____ Bills
- ____ Physician/clinical records
- ____ Implant details (including operative report)
- ____ Photos

Release of the following information may be governed by additional laws. I am aware and agree that this information will be disclosed only if I place my **<u>initials</u>** in the space below.

- _____ HIV/AIDS information
- ____ Mental health information
- ____ Genetic testing information
- ____ Drug/alcohol diagnosis, treatment, or referral information

Page 2 of 2

Patient Initials

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