ORTHOPAEDIC SPECIALTY INSTITUTE

Medical Information Release Form (HIPAA Release Form)

Patient Name: _____Date of Birth: ___/___/_____ MR #: _____

If minor, Parent/Guardian Name: _____

Release of Information

I authorize the release of information including diagnosis, records, examination results, medication dose changes and billing/collection/claims information.
This information may be released to:

[ ] Spouse/Name: _____

[ ] Child(ren)/Name(s): _____

[ ] Other: _____

[ ] Information is not to be released to anyone other than me.

Messages

Please call: [ ] my home phone # _____ [ ] my cell phone # _____.
If unable to reach me:

[ ] you may leave a detailed message.
OR
[ ] please leave a message asking me to return your call.

[ ] Do not leave messages on my voicemail.

The best time to reach me is (day of week) _____ between (time) _____.

E-mail Messages/Portal

[ ] Use my e-mail or portal contact to send messages for me to contact the nurse for information.
OR
[ ] Use my e-mail or portal contact to leave detailed messages and information.
[ ] Attach lab results to e-mail/portal message.
My e-mail address is: _____.

This Release of Information will remain in effect until termination by me in writing. This release specifically excludes any psychiatry and psychology evaluations/records which are further restricted by HIPAA regulations.

Signature: _____ Date: _____

Witness: _____ Date: _____