NORTH COUNTRY
ORTHOPAEDIC GROUP ™

Patient Authorization to Release Protected Health Information (PHI)

Patient Name _____ **Date of Birth**_____

Address _____ **Phone #** _____

[1] I authorize _____ to release protected health information from the medical records of the above-named patient.

[2] This information may be disclosed to (*name & address*): _____
_____.

[3] I authorize this information to be disclosed via:

- □ Patient Portal
- □ Patient pick-up
- □ Mailed to address above
- □ Emailed to: _____
- □ Faxed to: _____

[4] The type and amount of information to be used or disclosed is as follows:

- □ Most recent office note
- □ Operative report
- □ Physical Therapy notes
- □ Images & reports only
- □ All for body part (*please list*) _____
- □ Other (*please describe*) _____

[5] This information is being used or disclosed for the following purposes:

- □ At the request of the individual
- □ Other _____

I understand that once information is disclosed pursuant to this authorization, it may be re-disclosed by the recipient and the information may not be protected by federal privacy regulations.

[6] Unless otherwise revoked, this authorization will expire on the following date: _____
(If I fail to specify an expiration date, this authorization will expire six (6) months from the date of signing)

I, the undersigned, have read the above and authorize the staff of the disclosing facility named to disclose such information as herein contained. I understand that this authorization may be withdrawn by me by notifying my provider in writing at any time except to the extent that action has been taken in reliance upon it. The provider is released and discharged of any liability and the undersigned will hold the provider harmless for complying with this 'Authorization for Release of Protected Health Information (PHI)'.

_____ _____
Signature of Patient, Parent or Legal Guardian Date

_____ _____
Printed Name of Patient, Parent or Legal Representative Relationship/Authority