JORDAN-YOUNG INSTITUTE

ORTHOPEDIC SURGERY • SPORTS MEDICINE
NEUROSURGERY • PHYSICAL MEDICINE & REHABILITATION

AUTHORIZATION FOR RELEASE OF MEDICAL RECORDS

I authorize _____ to release records to:

_____ Name

_____ Phone

_____ Address

_____ Fax

_____

_____ E-mail

Records to be Released:

□ Office Visit Notes
□ Operative Reports
□ Diagnostic Study Reports (XRAY, MRI, EMG, CT, etc)
□ Physical Therapy Records
□ Radiology Images (**$10 XRAY CD**)
□ Itemized Billing Statement

_____ Treating Physician

_____ Body Part

_____ Dates of Services

☐fax ☐pick up ☐ email ☐mail

Patient Information:

_____ Name

_____ Date of Birth

_____ Daytime Phone Number

_____ Signature

Date

Please indicate your acceptance by checking the following boxes:

□ I understand that I may revoke this authorization in writing at any time except to the extent that action has been taken in reliance upon this authorization (45 CFR § 164.508(c)(2)(i)).

□ I understand that treatment or payment cannot be conditioned on my signing this authorization, except in certain circumstances such as for participation in research programs, or authorization of the release of testing results for preemployment purposes (45 CFR § 164.508(c)(2)(ii)).

□ I understand that my records are confidential and cannot be disclosed without my written authorization except when otherwise permitted by law. Information used or disclosed pursuant to this authorization may be subject to redisclosure by the recipient and no longer protected. I understand that the specified information to be released may include, but is not limited to history, diagnosis, and/or treatment of drug or alcohol abuse, mental illness, or communicable disease, including Human Immunodeficiency Virus (HIV) and Acquired Immune Deficiency Syndrome (AIDS) (45 CFR § 164.508(c)(2)(iii)).

This authorization will expire One Hundred Eighty (180) days from the date of my signature unless I revoke the authorization prior to that time.