PATIENT AUTHORIZATION TO RELEASE MEDICAL INFORMATION

COLUMBUS ORTHOPAEDIC CLINIC & OUTPATIENT CENTER

This form allows Columbus Orthopaedic Clinic, PA, to release your records on your behalf.

Columbus Orthopaedic Clinic | **Medical Records Department**
670 Leigh Drive Columbus, MS 39705 | Phone: 662-328-1012 | Fax: 662-328-1507

Patient name: _____ DOB: _____ Last four digits of SSN: _____

Address: _____

City: _____ State: _____ Zip code: _____

PATIENT INFORMATION IS NEEDED FOR: PLEASE SELECT ONE OPTION

☐ Continuing medical care ☐ Military ☐ Personal use ☐ Form ☐ Insurance

☐ Legal purposes ☐ Social Sec./Disab. ☐ Records ☐ Other _____

DATE(S) OF TREATMENT: _____

I hereby authorize Columbus Orthopaedic Clinic, PA, its affiliates, medical staff, employees and their representatives to release my protected health information in the manner listed below, and to the following:

CHOOSE ONLY ONE METHOD TO SEND BY: ☐ Mail ☐ Fax ☐ Secure email (records will expire after 60 days if left unopened)

Records requested:

☐ All records (notes, labs, reports, images and OP notes)

☐ Disc of ALL images (only)

☐ Specific item only (please list): _____

If images are requested, a mailing address must be provided or records will not be sent.

☐ Send to or receive records from:

Name: _____

Address: _____

City: _____ State: _____ ZIP code: _____

Phone: _____ Fax: _____ Email: _____

There may be a charge for copies of records, in accordance with federal and state laws.

This authorization is effective one (1) year from the date signed below, except when revocation or modification is requested in writing by the patient, legal guardian, power of attorney or health care surrogate accompanied by the applicable documentation. I understand that I have the right to revoke or modify this authorization at any time. I understand that If I revoke or modify this authorization, I must do so in writing and present my written request to the Medical Records Team. Additionally, I acknowledge my responsibility to confirm receipt by Columbus, Orthopaedic Clinic PA, of such revocation or modification; such confirmation is required via certified mail. I understand that the revocation or modification will not apply to information that has already been released in response to this authorization. I understand that once the information is disclosed, it may be rediscovered by the recipient and the information may not be protected under federal privacy laws or regulations.

I understand Columbus, Orthopaedic Clinic PA will not condition treatment or payment based on this authorization or revocation of authorization unless otherwise allowed by law. A copy of this authorization may be utilized with the same effectiveness as an original. I am entitled to receive a copy of this authorization.

_____ _____

Signature of patient/guardian/power of attorney/health care surrogate Date

_____ _____

Printed name Relationship to patient

Use one form for each person from whom you wish Columbus, Orthopaedic Clinic PA to obtain your health information. You may copy this form as often as needed.

If you do not have a digital signature please print out form and sign it.

Updated: 12/7/2018