THE CENTER FOR BONE & JOINT CARE
A DIVISION OF ORTHOPEDIC PARTNERS

Authorization to Use & Disclose Protected Health Information

ORTHOPEDIC PARTNERS
Formerly Norwich Orthopedic Group
EST. 1957

Location: _____

Patient Information

Patient Name (Please Print): _____ Date of Birth: _____
Any other Previous Names: _____
Patient Address: _____ Phone #'s: _____
City: _____ State: _____ Zip: _____ EMAIL: _____

I hereby Authorize:

Check one: _____ Orthopedic Partners _____ Bone & Joint Care

Please choose one: ○ Release my medical record information to ○ Obtain medical information from

Name/Facility: _____ Attention: _____
Address: _____ Phone #: _____
City: _____ State: _____ Zip: _____ Fax #: _____

Purpose of Request: ○ Personal ○ Referral or 2nd Opinion ○ Legal ○ Insurance ○ Other _____
○ Workers Comp (only) Date of Injury _____ Body Part Treated _____

Specific Records/Report(s) to be released: (allow 7 to 10 days for turnaround of request)

Dates of Service _____

○ Consultation\Progress Reports
○ Physical Therapy Notes
○ Other (Please Specify) _____
○ Radiology Reports
○ Operative/Surgery Notes
○ Bills
○ Entire Record (ONLY when subsections of the record will not serve the intended purpose of the disclosure).
○ Radiology Films

Restricted Authorization to Release Protected Information:

STOP **IMPORTANT -** It is extremely important that you select either you "**DO**" or "**DO NOT**" for each item contained in this section *Authorization to Release Protected Information*. Please do not skip any line item as it could impact our ability to fulfill your request and cause additional delays.

Release Records? Check one

I ☐	**DO**	☐	**DO NOT** want **Mental/Behavior Health or Disability Services Provider Documentation *** released**.**
I ☐	**DO**	☐	**DO NOT** want **HIV/AIDS Screening Test Results** released
I ☐	**DO**	☐	**DO NOT** want information about **Alcohol and/or Substance Abuse Treatment** *** released
I ☐	**DO**	☐	**DO NOT** want **Genetic Testing/Test Results **** released
I ☐	**DO**	☐	**DO NOT** want **Confidential Communications with a Social Worker** released
I ☐	**DO**	☐	**DO NOT** want information about **Rape/Sexual Assult Victim's Counseling** released
I ☐	**DO**	☐	**DO NOT** want **Child/Elder Abuse or Neglect & Abuse of an Adult with a Disability** released
I ☐	**DO**	☐	**DO NOT** want information about **Sexually Transmitted Disease (STD's)** released
I ☐	**DO**	☐	**DO NOT** want information about **Domestic Violence Victim's Counseling** released

* This Authorization is not valid for use or disclosure of psychotherapy notes.

** The term "genetic tests" means only those tests which determine your future chances of developing a disease, not test done to diagnose a current condition or problem. This includes information related to the testing of embryo's created during IVF.

*** Only applicable to records that are created by an "individual or entity who holds itself out as providing alcohol or drug abuse diagnosis, treatment or referral for treatment" (42 CFR Part 2). Does not include records created or maintained by a general medical facility.

Sign Here _____ Date Here _____

Signature of Patient's **Date**

Signature of Personal Representative **Date** **Relationship to patient or authority to act for patient**

Term: This Authorization will remain in effect until the facility fulfills this request, or if unchanged, one year from the signature date.
Revocation: I understand that I may revoke this Authorization at any time by requesting it in writing at the address listed below. The revocation will be effective immediately upon receipt of my written notice. I understand that the revocation will not have any effect on any action taken by the facility above in reliance on this Authorization before it received my written notice of revocation.
Effect on Treatment: I understand that I may refuse to sign this Authorization for any reason and that such refusal will not affect the commencement, continuation or quality of my treatment.
Potential for Re-disclosure: I understand that the person receiving my Protected Health Information may not be required to comply with federal and state Privacy laws, and my Protected Health Information may no longer be protected by the applicable state and federal law once it is disclosed by the facility above.
Access: I understand that in certain circumstances the facilities above have the right to deny me access to all or portions of my Protected Health Information and must notify me in writing of any such denials