PRO SPORTS ORTHOPEDICS

AUTHORIZATION TO DISCLOSE MEDICAL RECORD INFORMATION

Patient Information

Patient's Name: _____Telephone #: _____

Patient's Address: _____ D. O. B.: _____

City: _____ State: _____ Zip: _____ Email: _____

Release Information To

Name: _____ Telephone #: _____

Address: _____ Fax #: _____

City: _____ State: _____ Zip: _____ Email: _____

How Would You Like To Receive This Information? (*please check off all that apply*)

◯ Mail ◯ Fax ◯ Email ◯ Pick Up (*please specify Pro Sports office location:* _____)

Purpose Of Request

◯ Personal ◯ Legal Matter ◯ Other (please specify: _____)

Information To Be Released (*please check off all that apply & specify dates*)

◯ Office Visits _____ to _____ ◯ Operative Notes _____ to _____

◯ Billing: _____ to _____ ◯ Imaging Reports _____ to _____

◯ Other: _____ to _____ ◯ Complete Medical Record

◯ X-ray Images _____to _____ *(specify how you would like to receive your x-rays: ◯Email ◯ Mail)*

Protected Under State Law (*must be checked off to have information released*)

◯ Alcohol/Drug Abuse ◯ Psychotherapy Notes ◯ HIV/AIDS ◯ Genetic Testing

I Understand and Agree that:

- I have signed this Authorization voluntarily, and these records are released at my request. Except to the extent allowed by law, Pro Sports Orthopedics, Inc. will not condition treatment on my signing this Authorization.
- I may revoke this Authorization in writing at any time except to the extent that action has been taken in reliance on it. To revoke this Authorization, a written request must be submitted to the Compliance Officer at 20 Guest St, Suite 225, Brighton, MA 02135.
- Any disclosure carries the potential for un-authorized re-disclosure and therefore may no longer be protected by state or federal privacy laws. I further understand that Protected Health Information which is emailed may or may not be encrypted. I release Pro Sports Orthopedics, Inc. from any legal liability that may arise from the disclosure or re-disclosure of this information.
- If Pro Sports Orthopedics Inc. maintains any of my records from outside providers, these will not be released unless I specifically ask for them under "Other" in the "Information To Be Released" section. Please include entity name, provider, and specific dates if known.
- This authorization will automatically expire **1 year from the date signed** unless otherwise specified: _____/_____/_____.
- I have read and understand the above statements and authorize the disclosure of the information requested above.

X_____ _____ _____ _____

Patient or Authorized Representative's Signature *Print Name* *Relationship to Patient* *Date*

This authorization must be completed in its entirety or it will not be processed.