OXFORD ORTHOPAEDICS
& SPORTS MEDICINE, PLLC

Authorization for the Release of Protected Health Information

*** Required Information**

***Name: _____ Contact #:_(_____)_____-_____**

***Date of Birth: ____/_____/_____**

*Release from:	*Send to:
_____ (Name of Group)	_____ (Name of Recipient)
Address: _____	Email (preferred): _____
City: _____	Fax: _____
Zip: _____	Address: _____
Sender: _____	_____ (3-5 days by mail)

***I authorize the following PHI for disclosure: Circle or highlight**

Operative Notes ER Report History and Physical Labs Imaging

Office Visit Note/s Discharge Summary Physicians Orders Consultation

Entire Chart Specify Other: _____

***Date Range: ____/_____/_____ - _____/_____/_____ or Present**

I authorize the release of any records regarding drug, alcohol, or mental health treatment to the person(s) listed above. *_____(initial). **I authorize** the release of my STD results, HIV/AIDS testing, whether negative or positive, to the person(s) listed above. **I understand** that the person(s) listed above will be notified that I must give specific written permission before disclosure of these test results to anyone.
*_____
(initial)
I understand that I have the right to revoke this authorization at any time. **I understand** that I must do so in writing and present the written revocation to entity requesting from. **I understand** that the revocation will not apply to information that has already been released to this authorization. **I understand** that information disclosed by this authorization, except for Alcohol and Drug Abuse as defined in 42 CFR Part 2, may be subject to re-disclosure by the recipient and may no longer be protected by the Health Insurance Portability and Accountability Act Privacy Rule [45 CFR Part 164] , and the Privacy Act of 1974 [5 USC 552a]

* Patient's Signature:_____ * Date:_____

This authorization expires one year from the above dated signature.

Acton Corporation contracts to provide records requests 205.408.6030 or 888.678.7227 for status check.