Archway Orthopedics and Hand Surgery

Medical Information Release Form
(HIPAA Release Form)

Patient Name: ______________________________________ Date of Birth: _________________

RELEASE OF INFORMATION AND ASSIGNMENT OF BENEFITS

I hereby authorize my physician (or whomever he may designate) to administer medical treatment as is necessary for a patient in my condition. I hereby authorize Archway Orthopedics and Hand Surgery to release any and all information acquired as the course of my examination or treatment which may be requested by guarantors, insurers, managed care or similar network organizations or payers of my account. In addition, I authorize payment of medical benefits to Archway Orthopedics and Hand Surgery.

ACKNOWLEDGEMENT OF RECIEPT OF PRIVACY NOTICE

I have been provided with a Notice of Privacy Practices that describes the uses and disclosures of certain health information. I understand that I have the right to review the notice prior to signing this consent. I understand that the organization reserves the right to change their notice and practices and prior to implementation will provide a copy or any revised notice.

DISCLOSURE OF PROTECTED HEALTH INFORMATION TO ANOTHER PARTY

I also authorize Archway Orthopedics and Hand Surgery to use and/or disclose certain protected health information (PHI) about me to the party or parties listed below.

Release of Information:

☐ I authorize the release of information including the diagnosis, records; examination rendered to me and claims information. This information may be released to:

☐ Spouse__________________________________

☐ Child(ren)_______________________________

☐ Other___________________________________

☐ Information is not to be released to anyone.

Check applicable information:

_____Medical Information

_____Testing/Radiology/MRI Results

_____Billing/Insurance Information

_____Authorized to leave message on voice mail

_____Other, describe ____

This Release of Information will remain in effect until terminated by me in writing.

____ ____

Signature of Patient or Legal Guardian | Relationship to Patient if Guardian

____ ____

Print Name of Patient or Legal Guardian | Date

Revised 6/24/15