AUTHORIZATION TO RELEASE/OBTAIN MEDICAL RECORDS

I authorize Tower Orthopedic and Joint Replacement/Stephen S. Tower, MD, to _____release / ____obtain a copy of medical information for:

PATIENT NAME_____ DATE OF BIRTH _____ TODAY'S DATE/EFFECTIVE DATE _____

This information may be _____released to / ____obtained from:

Name of physician/clinic: _____ Phone: _____

Address: _____ Fax: _____

City/State/Zip: _____

Information requested for the following purpose: ____ patient treatment _____ payment/billing _____healthcare operations

By checking or initialing the spaces below, I specifically authorize the use or disclosure of the following health information and/or records, as such information and/or records exist:

_____ Entire medical record (all information, including x-ray reports-disc of images must be obtained from the imaging center where taken)

OR

_____ Medical records needed for continuation of care _____ Laboratory and/or Pathology reports _____ Office chart notes
_____ Hospital surgery reports by Dr. Tower _____ Diagnostic imaging/x-ray reports _____ X-Ray images
_____ Billing statement/full account ledger
_____ Other: _____

- I understand that the information in my health record may include information relating to sexually transmitted disease, acquired immunodeficiency syndrome (AIDS), or human immunodeficiency virus (HIV). It may also include information about behavioral or mental health services, and treatment for alcohol and/or drug abuse. I also understand it will not be released without my specific authorization.
- As outlined in Tower Orthopedic and Joint Replacement's Notice of Privacy Practices, I understand I have the right to revoke this authorization at any time. I understand that if I revoke this authorization, I must do so in writing and send it to TOJR. I understand that this will not apply to information that has already been released as a result of this authorization. I understand that the revocation will not apply to my insurance company when the law provides my insurer with the right to contest a claim under my policy. ***Unless otherwise revoked or specified below, this authorization will expire 6 months from the date it was completed.*** _____ (Patient initials/date)
- I understand that authorizing the disclosure of this health information is voluntary. I can refuse to sign this authorization. I do not need to sign this form to assure treatment. I understand that I may inspect or copy the information to be used or disclosed, as provided in 45 CFR 184.524. ***I understand that any disclosure of information carries with it the potential for an unauthorized re-disclosure and may no longer be protected by federal confidentiality rules.*** If I have questions about disclosure of my health information, I can contact TOJR.
- I understand that the first copy of my record and subsequent updates will be free of charge when they are requested by and given to me. If any additional copies of the entire chart are requested, a fee for labor, cost of supplies, and postage will be charged; the final cost will depend on the size of the chart. _____ (Patient initials/date)
  PLEASE NOTE: These are your copies. If you take them to another physician, a lawyer, etc., it is advisable that you make a copy for yourself first.

_____ _____ _____
Signature of Patient/Legal Representative | Date Signed | Expiration Date of Authorization

_____ _____
Relationship if other than patient | Authority to Act as Patient Representative (Legal guardian, Power of Attorney, etc.)

FOR OFFICE USE ONLY
Date Completed _____ Completed by _____