AUTHORIZATION TO RELEASE AND DISCLOSE PATIENT INFORMATION

JORDAN-YOUNG INSTITUTE
ORTHOPEDIC SURGERY • SPORTS MEDICINE
NEUROSURGERY • PHYSICAL MEDICINE & REHABILITATION

PATIENT INFORMATION	Name: _____ Date of Birth: _____ Address: _____ Day Phone: _____ City: _____ State: _____ Zip: _____
I authorize the use or disclosure of the above named individual's health information as described below:	
Release From: Clinic / Health Care Provider – (**Who** has the information you want released?) **Please list the specific hospital or clinic.**	Name: _____ Address: _____ Day Phone: _____ City: _____ State: _____ Zip: _____
Release to: Receiving Party (**Where** do you want the information sent? **Who** may have the information?)	Name: _____ Attention to: _____ Address: _____ Day Phone: _____ City: _____ State: _____ Zip: _____ Fax Number (**URGENT PATIENT CARE ONLY**): _____
Information to be Released (**What** do you want sent or released? Check the appropriate box.) *Please be advised, Jordan Young Institute utilizes a shared medical record system. It is possible to receive records from providers outside of JYI. Please review the information to the right to ensure your authorization covers the information you wish to release.*	Indicate date(s) of service: _____ ☐ **My entire record (except for records concerning highly confidential information)** Only record types checked below: ☐ Discharge Summary / Note ☐ Radiology Reports ☐ Emergency Record(s) ☐ History & Physical Exam ☐ Rehab Records (PT/OT/ST) ☐ Medication Records ☐ Immunization/Allergy Record ☐ Operative Reports ☐ Laboratory Reports ☐ Progress Notes / Clinic Notes ☐ Pathology Reports ☐ Consultation ☐ Treatment / Care Plan ☐ Other Records – specify record type(s): _____ **By checking any of the boxes next to a category of Highly Confidential Information listed below, I specifically authorize the use and / or disclosure of this information:** **MUST BE CHECK MARKED & INITIALED TO BE VALID:** ☐ Mental Health Information _____ ☐ HIV / AIDS Testing or Treatment _____ ☐ Sexually Transmitted Diseases _____ ☐ Developmental disabilities Information _____ ☐ Genetic Testing _____ ☐ Alcohol and / or Drug Abuse _____ ☐ Sexual Assault _____ ☐ Abuse or Neglect _____ OPTIONAL Limits – Disclose only records related to following: Date(s) of service: _____ Injury / Illness: _____
Release Instructions (**When** do you want the information?)	Date information is needed: _____ **(NOTE: PLEASE ALLOW 30 DAYS FOR PROCESSING)**
Purpose of Release (**Why** is it needed?)	☐ Continuing Care ☐ Transfer of Care ☐ Social Security Appeal ☐ Insurance Application ☐ Personal Use or Review ☐ Social Security Disability Determination ☐ Litigation / Legal ☐ Other: _____ ***Fees may be charged in accordance with State Statutes.**
This authorization will remain in effect:	From the date of this authorization until _____, unless otherwise revoked. If I fail to specify an expiration date, this authorization will expire **1 year** from the date of signature on this form.

I understand that:

- Authorizing the disclosure of this health information is voluntary. I can refuse to sign this authorization for any reason, which will **prevent disclosure of information.**
- The above persons or organization authorized to make the requested disclosure **may not restrict or condition treatment** or payment upon completion of this form.
- I have the **right to inspect or copy the information** to be used or disclosed.
- Any disclosure of information carries with it the potential for an unauthorized redisclosure and the information **may not be protected** by federal or state privacy laws.
- I have **the right to revoke** this authorization in writing at any time. If I wish to do so, I must send written notification to HealthMark or Jordan Young Institute. The revocation will not apply to information that has already been released in response to this authorization.
- A photocopy / fax of this authorization will be treated in the same way as an original.
- If I have questions about disclosure of my health information, I may contact the HealthMark @ 800-659-4035 or Jordan Young Institute Privacy Officer.

_____ _____
Patient / Legal Guardian Signature Date Relationship to Patient if Signed by Authorized Representative

_____ _____
Witness Signature Date

AUTHORIZATION TO RELEASE AND DISCLOSE PATIENT INFORMATION