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.)	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

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Relationship to Patient if Signed by Authorized Representative

______________________________ ______________
Witness Signature Date

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