CONSENT TO RELEASE PROTECTED HEALTH INFORMATION (PHI)

PATIENT INFORMATION

Last Name, Frist Middle: _____

Aliases/Previous Name(s): _____

DOB (MM/DD/YYYY): _____ **Tel:** _____ **Email:** _____

Mailing Address: _____

AUTHORIZES

Name of Medical Practice: **Premier Orthopaedics & Sports Medicine**

Mailing Address: **PO Box 1939, Fort Oglethorpe, GA 30742** Email: **service@premierosm.com** Fax: **855-823-7569**

TO DISCLOSE TO

❑ **Self, Delivery Options:** ❑ Email ❑ Fax ❑ Mail to patient's mailing address as identified above.

❑ **Healthcare Provider, Plan, Other**

Name: _____

Tel: _____ **Fax:** _____ **Email:** _____

Mailing Address: _____

DATE(S) OF INFORMATION TO BE DISCLOSED (If left blank, only information from the past 24 months will be disclosed.)

From (MM/YYYY): _____ **To (MM/YYYY):** _____

INFORMATION TO BE DISCLOSED (Check all that apply)

❑ **All Medical Records Related to (specify condition, treatment, etc):** _____

❑ **Operative Report(s) (specify surgery/body location):** _____

❑ **Radiology Report(s) (specify test/body location):** _____

❑ **Radiology DICOM Image(s) (specify test/body location):** _____

EXPIRATION (If this item is left blank, the authorization will expire in 12 months from the date signed.)

This Authorization is good until the following date/event: _____

PURPOSE (Check all that apply)

❑ Transfer of Care ❑ Insurance Eligibility/Benefits ❑ Personal Use (at my request) ❑ Other: _____

YOUR RIGHTS WITH RESPECT TO THIS CONSENT

I am aware that I have the right to inspect and receive a copy of the health information I have authorized to be used and/or disclosed by this Consent. I understand that I may be charged a fee for record copies. In addition, I understand that I do not need to sign this Consent in order to receive treatment. I also am aware that I may revoke this Consent by notifying Premier Orthopedics and Sports Medicine in writing. However, I understand that my revocation will not be effective as to uses and/or disclosures: (1) already made in reliance upon this Consent; or (2) needed for an insurer to contest a claim/policy as authorized by law if signing the Consent was a condition to obtaining insurance coverage. I realize that the information used and/or disclosed pursuant to this Consent may be subject to re-disclosure and no longer protected by federal privacy law.

_____ _____

PRINTED NAME (Patient/Responsible Party) **RELATIONSHIP TO PATIENT**

X _____ _____

SIGNATURE (Patient/Responsible Party) **DATE (MM/DD/YYYY)**