


Authorization For Use or Disclosure of Medical Record Information

Medical Record #

Patient Information	
Patient Full Name: _____	Date of Birth: _____
Patient Address: _____	Phone: _____
City: _____ State _____ Zip: _____	

Release Information To	I authorize Aspen Orthopaedic Associates to release my medical records to the following:
Send Records To: (Mailing Address Required)	<input type="checkbox"/> Mailing Address <input type="checkbox"/> Email Address
Name/Facility: _____	Attention: _____
Address: _____	Phone: _____
City: _____ State _____ Zip: _____	Email: _____
Purpose of Request: <input type="radio"/> * Personal <input type="radio"/> Continuing Care <input type="radio"/> * Legal <input type="radio"/> * Insurance <input type="radio"/> * Other _____	

Information to be Released	PLEASE BE SPECIFIC - include dates of treatment & provider name if applicable.
_____	Date(s) of Treatment _____
_____	Date(s) of Treatment _____
_____	Date(s) of Treatment _____

Authorization for Release of Statutorily Protected Information	
DO NOT Leave This Section Blank - The requested medical record MAY or MAY NOT contain information that is statutorily protected. You must check either "Yes" or "No" and initial each category for Aspen Orthopaedic Associates to properly process your medical record request.	
Release Records? Check one	
	Yes or No
Mental Health	<input type="checkbox"/> <input type="checkbox"/>
HIV Tests & Related Information	<input type="checkbox"/> <input type="checkbox"/>
Alcohol and/or Substance Abuse	<input type="checkbox"/> <input type="checkbox"/>
	Initial Here: _____
	Initial Here: _____
	Initial Here: _____
 Please confirm that you have checked "Yes" or "No" and initialed all 3 protected information categories above even if they do not necessarily apply to the patient's records. If information is not released and/or form is incomplete, Touchstone may be unable to fulfill this request.	

Sensitive Information	Please check or indicate below any sensitive information that you DO NOT want released.
<input type="checkbox"/> Abortion	<input type="checkbox"/> Sexually Transmitted Disease
<input type="checkbox"/> Genetic	<input type="checkbox"/> Domestic Sexual Assault
	<input type="checkbox"/> AIDS/ARC
	<input type="checkbox"/> Other(s) _____

Patient's Signature	Date*
Parent/Legally Recognized Representative Signature/Relationship To Patient**	Date*
Witness	Date

Know Your Privacy Right
 refer to the HIPAA
"PRIVACY NOTICE"

*This Authorization is valid for 90 days (30 days for alcohol/drug abuse treatment) unless you specify other wise: _____. You may revoke this Authorization at any time by providing a written statement to the AOA clinic where the Authorization was originally submitted, except to the extent that AOA has already completed action on it.
 ** By my signature, I attest that I am the legally recognized representative of the above mentioned patient in accordance with the following: _____
 The information release pursuant to this Authorization may be redisclosed by the receiving institution or individual to other individuals or organizations that are not subject to privacy protection laws. AOA will not condition treatment or payment of the provision of this Authorization. Patient does have a right to receive a copy of this form