

Revocation
Date Revoked: _____
Initials of Privacy Official: _____

Patient name (first, last)		Date of Birth	
Patient's residential address	City	State	Zip Code
Home Phone #	Cellular Phone #	Email Address	

I would like to disclose the following records:

Entire Written Record
(Does not include x-ray images or billing records)

OR

Date span from _____ to _____
including the following types of records:

- | | |
|---|--|
| <input type="checkbox"/> Diagnostic Reports | <input type="checkbox"/> Physician's Office Notes |
| <input type="checkbox"/> Medication & Treatment Records | <input type="checkbox"/> Billing Records |
| <input type="checkbox"/> X-ray images on disc (prepayment required) | <input type="checkbox"/> Other (Please describe below) |

I would like these records provided to:

- | | |
|--|--|
| <input type="checkbox"/> Myself (via mail or e-mail – to patient only) | <input type="checkbox"/> Attorney's Office (via mail only) |
| <input type="checkbox"/> Provider's Office (via mail only) | <input type="checkbox"/> Other: _____ |

Send these records via:

- USPS Mail to: _____

- E-mail to: _____

To disclose records to additional recipients list addresses here:

_____	_____
_____	_____
_____	_____
_____	_____

Authorization Statements/Signatures:

I understand that once the above information is disclosed it may be re-disclosed by the recipient. At which point the HIPAA Privacy Rule may no longer protect the information.

I understand I have the right to revoke this authorization at any time. I understand that if I revoke this authorization, it must be done in writing and delivered in person by me to a licensed OrthoConnecticut staff member. I understand that revocation will not apply to information that has already been released in response to this authorization.

I understand that the Facility will not condition the provision of treatment or payment on the provision of this authorization.

I understand Medical Records can only be mailed to an outside office (i.e., Provider, Attorney) and can only be mailed or e-mailed to myself.

I understand there may be a charge of up to .65 per page plus postage for my records.

Signature of Patient or Personal Representative

Date

Print Name

Personal Representative's Title or Relation to Patient

This Authorization for Release form is valid for up to 1 year from the signature date unless an earlier date is specified here:

Date