HEALTHMARK GROUP

I AUTHORIZE PRECISION ORTHOPEDICS & SPORTS MEDICINE TO RELEASE MEDICAL RECORDS INFORMATION

PROVIDE THE PATIENT'S INFORMATION:

Name: Date of Birth:

Email: Phone:

HOW WILL WE RELEASE THE INFORMATION (SELECT ONE OPTION)

☑ **By Secure Email** ☐ By Fax

☐ By Mail* **(7 – 14 days delivery, dependent upon USPS)** ☐ **In Office Pick Up (additional fees will apply)**

WHO/WHERE WILL WE RELEASE THE INFORMATION TO (SELECT ONE OPTION)

Clinic/Doctor's Name: **Summit Orthopedics of Texas**

☑ **Send Email Link To:** office@summitorthotx.com ☐ Fax To:

☐ Mail To This Address:

City: ST: Zip Code:

PROVIDE THIS INFORMATION ON THE RELEASE:

Dates of Service

☐ Please provide a complete copy of my file for service **from** _____ **through** _____

☑ Please provide a copy of my file **for all dates of service**.

Records to be Released (45 CFR § 164.508(c).

☐ All Medical Records ☑ Office Notes ☐ Lab Reports ☑ Radiology Reports ☑ Radiology Images ☑ Operative Reports

☐ Other _____

Purpose for Disclosure

☐ Continuing Care ☑ Transfer of Care ☐ Referring Physician ☐ Disability

☐ Legal/Attorney ☐ Insurance ☐ Patient Request ☐ Other _____

Please indicate your acceptance by checking the following boxes:

o I understand that I may revoke this authorization in writing at any time except to the extent that action has been taken in reliance upon this authorization (45 CFR § 164.508(c)(2)(i)).

o I understand that treatment or payment cannot be conditioned on my signing this authorization, except in certain circumstances such as for participation in research programs, or authorization of the release of testing results for pre-employment purposes (45 CFR § 164.508(c)(2)(ii)).

o I understand that my records are confidential and cannot be disclosed without my written authorization except when otherwise permitted by law. Information used or disclosed pursuant to this authorization may be subject to redisclosure by the recipient and no longer protected. I understand that the specified information to be released may include, but is not limited to history, diagnosis, and/or treatment of drug or alcohol abuse, mental illness, or communicable disease, including Human Immunodeficiency Virus (HIV) and Acquired Immune Deficiency Syndrome (AIDS) (45 CFR § 164.508(c)(2)(iii)).

This authorization will expire One Hundred Eighty (180) days from the date of my signature unless I revoke the authorization prior to that time.

Signature: _____ Date: _____

Reason if patient is unable to sign:

_____

(Provide guardianship, executor of estate, death certificate, or power of attorney paperwork with request)

Please allow 5-7 business days for processing.
Questions? Contact HealthMark Group at (800) 659-4035 or status@healthmark-group.com