



Authorization for Use/Disclosure of Protected Health Information Form

I hereby authorize the use and disclosure of my individually identifiable health information as described below.

Patient Name: (Last) (First) (Middle / Maiden)

Date of Birth: Telephone #:

Purpose of Disclosure: Medical Needs Legal Review Insurance Review Personal Use Other

Medical Records: Please check the specific information to be released/disclosed and the related date(s) of service:

Clinical Notes Test Results Operative Note Medication List Work Status Form Itemized Bill PT Notes Entire Chart Other: Record(s) from to Pertaining to:

Fees: The minimum fee is \$25.00 per request - plus applicable postage (\$25.00 paid in advance).

Radiology/Imaging/Xray:

X-Rays Date(s): to Pertaining to:

Fees: Xray images can be placed on a CD at the cost of \$8.00 - plus applicable postage (\$8.00 paid in advance).

I authorize INOV8 Orthopedics to release the requested health information to:

Name/Organization:

Address:

City: State: Zip:

Telephone #: Fax #:

Please allow 7-10 business days for your request to be completed. (Texas State Board of Medical Examiners allows 15 business days)

Please check your preferred method for releasing the requested information:

- Fax to the number provided above
Mail to the address provided above. (applicable postage applies)
I will pick up my medical records at 10496 Katy Freeway, Ste 101 Houston Texas, 77043
Email (Service available only for X-Rays ONLY) to the address listed here:
I need to make other arrangements for picking up my medical records and or images.

Please note: We will contact you for payment and/or to coordinate a designated date & time to pick up records.

I understand that if the person or entity that receives this information is not a health plan or health care provider covered by federal privacy regulations, the released information may be re-disclosed by the recipient and may no longer be protected by federal or state law. I understand that I may revoke this authorization at any time by notifying INOV8. However, if I choose to do so, I understand that my revocation will not affect any actions taken by INOV8 before receiving my revocation. I understand that I may refuse to sign this authorization and that my refusal to sign in no way affects my treatment, payment, enrollment in a health plan or eligibility for benefits. *I understand that the information in my medical record may include information relating to treatment for drug or alcohol abuse, sickle cell anemia, psychological or psychiatric impairments, sexually transmitted disease, acquired immunodeficiency syndrome (AIDS), and AIDS related complex (ARC) and/or human immunodeficiency virus (HIV). This authorization will expire in 90 days, unless otherwise noted.

Signature: Date: (Patient/Minor/Emancipated Minor or Authorized Representative - Relationship: Spouse Parent Other:)

*Please note: the information following the asterisk above applies to minors as well as emancipated minors

Signature of Minor / Emancipated Minor: