Shoreline Orthopaedics

Authorization to Release Protected Health Information

Information to be released: (Check all that apply)

☐ Entire Medical Record ☐ Office Notes ☐ Surgery Reports

☐ Radiology Reports ☐ Radiology Films

☐ Other: _____

Person to Whom Information May Be Released: (Complete Address and Phone/Fax Number is required)

_____

Name Phone Fax

_____

Address

Expiration Date of Authorization

This authorization is effective through ___/___/_____ unless revoked or terminated by the patient or the patient's personal representative.

Right to Terminate or Revoke Authorization

You may revoke or terminate this authorization by submitting a written revocation request to the Practice Manager of Shoreline Orthopaedics.

Potential for Re-disclosure

Information that is disclosed under this authorization may be disclosed again by the person or organization to which it is sent. The privacy of this information may not be protected under the federal privacy regulations.

By signing this form, I am authorizing the release of my Protected Health Information as specified above to the individual named on this form. Please note that all records will be released electronically unless otherwise noted.

_____

Signature of Patient or Patient's Personal Representative (with relationship to Patient) Date

_____

Patient Name (please print) Patient's Date of Birth

_____

Shoreline Employee Signature

Office Use Only:

☐ Mailed Date _____

☐ Faxed Initials _____

☐ Patient Picked-up

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