Associates in Orthopedics
288 Groveland Street, Haverhill, MA 01830 | 978.383.3851
231 Sutton Street, N. Andover, MA 01845 | 978.725.0900

Authorization for Release of Protected Health Information

Patient Information	
Medical Record #:	Date of Birth:
Patient Name (Last, First, M.I.):	Telephone (Include area code):
Patient Address (Street, City, State, Zip Code:	

Description of Information to be Released (MUST INCLUDE DATES)	
Visit Notes (Dates):	X-Rays (Dates/Film):
X-Rays (Dates/Report):	Other (Please specify):

**Do you want this authorization to be used for medical records up to six months from today? ☐YES ☐NO
(If you select NO, then this authorization is only valid for medical records up to the signature date.)

Person Receiving Information	
I hereby authorize Associates in Orthopedics, PC to release my Protected Health Information to the following person(s) for the purpose(s) indicated.:	
Name (Last, First, M.I.):	
Address (Street, City, State, Zip Code:	
Telephone (Include area code):	Fax (Include area code):
Method: (Please check all that apply): ☐ Fax ☐ Mail ☐ Telephone	
Purpose: ☐ Medical Care ☐ Legal ☐ Insurance ☐ Personal ☐ Other (please specify): _____	

Specific Understanding:
I may revoke this authorization by notifying the Medical Records Department at any time in writing, but if I do, it won't have any effects on actions taken by Associates in Orthopedics, PC prior to receiving the revocation. Further details may be found in the Notice of Privacy Practices.
I may refuse to sign this authorization. My health care and the payment for my health care benefits will not be affected if I do not sign this form (except if health care services are provided to me solely for the purpose of creating health information for disclosure to a third party).
By signing this authorization form, I authorize the use or disclosure of my protected health information as described above. I understand that information used or disclosed pursuant to this authorization may be re-disclosed and may no longer be protected by federal or state law.
By signing below, I acknowledge that I have read this form and authorize the disclosure of protected health information as stated.

_____ _____
Signature of Patient or Legal Representative Date

If Representative, Please Specify Relationship to Patient: _____

THIS FORM MUST BE FILLED OUT ACCURATELY IN ORDER TO BE VALID **Effective 03/2015**