NEWPORT ORTHOPEDIC INSTITUTE

Authorization for Access/ Use/ Disclosure of Protected Health Information

I hereby authorize the access, use, or disclosure of my individually identifiable health information as described below. I understand that this authorization is voluntary. I understand that if the organization authorized to receive the information is not a health plan or health care provider, the released information may no longer be protected by federal privacy regulations.

Patient Name: _____ Date of Birth: _____

Address: _____APT#_____

City: _____ State: _____ Zip: _____

Telephone: _____ Cell: _____

Information to be Released

Medical record(s) for the dates from _____ to _____

Check all that apply: ☐ Office Note ☐ Operative Report ☐ Laboratory Result ☐ MRI Report ☐ Itemized Statement ☐ Other (please specify) _____

Radiology Image(s) for the dates from _____to_____

Check all that apply: ☐ X-ray ☐ MRI

This information is to be disclosed **to** the following individual or entity (**MUST BE COMPLETED**), **or SELF** ☐ (check here)

Name: _____Relationship: _____

Address: _____E-Mail Address: _____

City: _____ State: _____ Zip: _____

Telephone: _____ Fax Number: _____

Purpose of Release: ☐ Medical Care ☐ Legal Review ☐ Insurance ☐ Personal Use ☐ Other_____

Medical record copy fees are determined by both the nature/purpose of your request and the format/method of delivery.

Please Note: If requesting both Medical Records and Images there is a separate fee for each request.

Please check your preferred format/method for receipt/release of the information:

☐ Upload medical records to the Patient Portal **(there are no fees for this!)**

☐ Email medical records to the email address provided.

☐ Email Radiology images to the email address provided.

☐ Fax medical records to the number provided.

☐ Mail paper records to address provided.

☐ Mail CD of Radiology images to the address provided.

☐ Pick Up records at **Newport Office-22 Corporate Plaza Drive-→** Call (_____) _____-_____ when ready.

*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). I understand that I may revoke this authorization at any time by notifying Newport Orthopedic in writing, but if I do it won't have any effect on any actions Newport Orthopedic took before it received the revocation. I understand that Newport Orthopedic cannot make me sign this authorization as a condition to receive treatment from Newport Orthopedic except: (i) when Newport Orthopedic provides me with research-related treatment; or (ii) when Newport Orthopedic provides me with health care solely for the purpose of creating protected health information for disclosure to someone else. Newport Orthopedic, its employees, officers, and physicians are hereby released from any legal responsibility or liability for disclosure of the above information to the extent indicated and authorized herein. I understand that by signing below, I agree to and certifying my understanding of all statements above. This authorization will expire one year from the date of signature. **(This form MUST be completed before signing, signature must have date to be a valid/legal request.)**

_____ _____

Signature of Patient Patient Name

_____ _____

Relationship/Authority if signature is not that of patient Date

How to submit this form

Send the completed form to: 22 Corporate Plaza Drive, Newport Beach, CA 92660 via mail or via encrypted fax to: (949) 630-4924