AUTHORIZATION TO USE OR DISCLOSE HEALTH INFORMATION

Patient Name: _____ Date of Birth: _____SS# _____

Address: _____ Phone Number: _____

I authorize Orthopaedic Specialists of the Four States, LLC 444 Four States Drive Galena, KS 66739
Phone: 620-783-4441 Fax: 620-783-4195

(*Please mark appropriate box below and fill in the correct information)*

☐ **Disclose** information to: _____
_____
_____

Please list all information of the person for whom you want us to give information **TO**.

☐ **Receive** information from: _____
_____
_____

Please list all information of the person for whom you want us to **get** information **FROM**.

The type of information to be used or disclosed is as follows (check the appropriate boxes and include other information where indicated): Date(s) of Service: _____

□ Progress Notes
□ Procedure Reports
□ Entire Record
□ Other: _____

□ **Written** Diagnostic Test Reports (lab, radiology, etc)
□ Radiology Disc***: Please circle: X-RAY MRI ALL***
($5.00 fee will apply per disc)

This information for which I am authorizing disclosure will be used for the following purpose(s):

□ My personal records
□ Continuing Medical Care
□ Social Security/Disability

□ Legal Purposes
□ Insurance
□ Other: _____

I understand that the information in my medical record may include information relating to sexually transmitted disease, acquired immunodeficiency syndrome (AIDS), or human immunodeficiency virus (HIV). It may also include information about behavioral or mental health services, and treatment for alcohol and drug abuse.

I understand that I have a right to revoke this authorization at any time. I understand that if I revoke this authorization, I must do so in writing and present my written revocation to the Orthopaedic Specialists of the Four States, LLC staff. I understand that the revocation will not apply to information that has already been released in response to this authorization. I understand that the revocation will not apply to my insurance company when the law provides my insurer with the right to contest a claim under my policy.

Unless I specify differently, this authorization will expire within *6 months* from the date on which it was signed. I understand that once the above information is disclosed, it may be re-disclosed by the recipient and the information may not be protected by federal privacy laws or regulations.

PLEASE READ Fee Information: I understand that Orthopaedic Specialists of the Four States, LLC may charge a reasonable fee for the copying of my records as set by the State of Kansas. The current fee for records is $18.97 plus $0.63 per page for the first 250 pages and then $0.45 per page for additional pages. HIPAA requires that access be provided to the patient within 30 days unless an extension is requested. We will work hard to provide all requests subject to the patient authorization within this time period. Where the records are requested under subpoena or other method required by law, a faster response may be required.

I understand authorizing the use or disclosure of the information identified above is voluntary. I need not sign this form to ensure healthcare treatment.

_____ _____
Signature of patient or legal representative Date

If signed by legal representative, relationship to patient: _____

_____ _____
Signature of witness Date