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|  | **Roger W. Lidman, M.D., F.A.C.P.**  **Witold A. Turkiewicz, M.D.**  **John V. Mansoor, M.D.**  **Julianne S. Orlowski, D.O.**  **Megan E. Eshbaugh, D.O., F.A.C.O.I.** |

**Medical Record Release Form**

All disclosures are in compliance with Federal and State laws, including the Health Insurance Portability and Accountability Act of 1996 (HIPAA), governing the use and disclosure of Protected Health Information (PHI). I therefore authorize the Center for Arthritis (CFA) to:

\_\_\_\_\_\_\_ Disclose / Release to Name of Person\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

\_\_\_\_\_\_\_ Obtain from or Organization \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**I authorize the release of my medical records as indicated below.**

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Patient Signature Last 4 of SSN

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Printed Name Date of Birth

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Witness Date

INFORMATION REQUESTED: I hereby agree to this authorization and understand that it contains Personally Identifiable Information and PHI as defined by HIPAA to ensure accuracy. I understand I have the right to limit the type of information released and to revoke this authorization by submitting a notice, in writing, to CFA’s Privacy Officer. Unless revoked, this authorization will expire from one year of signature. If I choose to limit the information released, I understand that CFA might inform the requestor that portions of the record have been withheld. I understand the information disclosed might be subject to re-disclosure by the recipient and no longer be protected by CFA, who is hereby released from any legal responsibility or liability of the below information to the extent indicated and authorized herein.

\_\_\_\_\_ **ALL MEDICAL RECORDS** without exception, including: clinical notes, lab testing (including HIV), mental health treatment, alcohol or drug abuse testing & treatment, sexually transmitted disease, consultations, secondary records, etc

\_\_\_\_\_ **PARTIAL MEDICAL RECORDS** which may include HIV testing and treatment, mental health treatment, alcohol or drug abuse testing & treatment, sexually transmitted disease & other sensitive information. Please specify parts and dates to be released:

\_\_\_\_\_ Progress notes \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_ Lab Reports \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

\_\_\_\_\_ X-Ray Reports \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_ Hospital Notes \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

\_\_\_\_ Consultations \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_ Other: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Note to Recipient: This information has been disclosed to you from records whose confidentiality is protected by Federal and State laws (including HIPAA) and prohibits you from further disclosure without the written consent of the person to whom it pertains. Charges may apply for copies of medical records.