Sports Medicine North
ORTHOPAEDIC SURGERY, INC

One Orthopedics Drive
Peabody, MA 01960
Tel: (978) 818-6350
Fax: (978) 854-4843

Authorization for Release of Protected Health Information

Patient Information	
Medical Record #	**Date of Birth:**
Patient Name: *(Last)* *(First)* *(M.I.)*	**Telephone (Including Area Code):**
Patient Address: *(Street Address)* *(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 6 months from now?** ☐ **Yes** ☐ **No**
If you select No, this authorization is only effective for medical records up to the signature date.

Person Receiving Information:	
I hereby authorize Sports Medicine North to release my Protected Health Information to the following person(s) for the purpose(s) as indicated:	
Name:	**Street Address:**
City: **State:**	**Zip Code:**
Fax:	**Phone:**
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 Sports Medicine North 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.

Please refer to Sports Medicine North Policy for information on copying fees that may be associated with this request.

By signing below, I acknowledge that I have read this form and authorize the disclosure or 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.**

MY HIGHLY CONFIDENTIAL INFORMATION:

By signing below, I specifically authorize the use and/or disclosure of the following types of highly confidential information, if any such information will be used or disclosed pursuant to this Authorization:

[Note to patient: Please strike any of the bullet points listed below, to the extent you do not want the information disclosed by the Practice.]

- information about HIV/AIDS status
- information about genetic testing
- information related to confidential communications with a psychotherapist, psychologist, social worker, sexual assault counselor, domestic violence counselor or other allied mental health professional or human services professional
- information about treatment of substance abuse (alcohol or drug)
- information about venereal disease(s)
- abortion consent form(s)
- mammography records
- information about family planning services
- if I am an emancipated minor, information about treatment and diagnosis (except to my parents)
- information related to mental health community program records
- information about research involving controlled substances

_____ _____

Signature of Patient or Legal Representative **Date**

If Representative, Please Specify Relationship to Patient: _____

Release Received By: _____

Documents Completed By: _____

Date Completed: _____