Milwaukie | SPINE + SPORT

Patient Records Request Form

Section 1:

Patient Information

Name:	Insurance ID #:
Address:	DOB:
City:	State: Zip:
Phone: Fax:	Email

I, or my authorized representative, hereby authorize Milwaukie Spine and Sport, LLC and their respective employees, agents and subcontractors to disclose my Personal Health Information (PHI) and Insurance Record to the designee identified below

Section 2:

Authorized Designee(party to which information will be sent)

Name:	Relationship:
Address:	DOB:
City:	State: Zip:
Phone: Fax:	Email

In accordance the Health Insurance Portability and Accountability Act of 1996 (HIPAA), I understand that:

1. This authorization may include disclosure of information relating to ALCOHOL and DRUG ABUSE, SEXUALLY TRANSMITTED DISEASES, MENTAL HEALTH TREATMENT, except psychotherapy notes, and CONFIDENTIAL ACQUIRED IMMUNODEFICIENCY SYNDROME (AIDS), OR HUMAN IMMUNODEFICIENCY VIRUS (HIV) RELATED INFORMATION only if I place my initials on the appropriate line in Section III. In the event the health information described below includes any of these types of information, and I initial the line on the box in Section III, I specifically authorize release of such information to the person indicated in Section II.
2. If I am authorizing the release of HIV-related, alcohol or drug treatment, or mental health treatment information, the recipient is prohibited from re-disclosing such information without my authorization unless permitted to do so under federal or state law. I understand that I have the right to request a list of people who may receive or use my HIV-related information without authorization
3. I have the right to revoke this authorization at any time by writing to Milwaukie Spine and Sport, LLC. I understand that I may revoke this authorization except to the extent that action has already been taken based on this authorization.
4. I understand that signing this authorization is voluntary. My treatment at Milwaukie Spine and Sport, LLC will not be conditioned upon my authorization of disclosure.
5. Information disclosed under this authorization might be redisclosed by the recipient, and the redisclosure may no longer be protected by federal or state law.
6. THIS AUTHORIZATION DOES NOT AUTHORIZE US TO DISCUSS YOUR PERSONAL HEALTH INFORMATION AND INSURANCE RECORD WITH ANYONE OTHER THAN THE PERSON AUTHORIZED IN SECTION II.

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Section 3:

Specific Information Requested for Release

- ❏ Please release my entire Medical Record, including patient histories, office notes, billing records, referrals and insurance records(excluding psychotherapy notes, test results, radiology studies, films and consults sent to Milwaukie Spine and Sport, LLC by health care providers).

- ❏ Please release only the following documents:
  - ❏ Chart Notes/Health Record
  - ❏ Billing Statements
  - ❏ Insurance Documents
  - ❏ Referrals

- ❏ Please release these additional documents:

Include: (Indicate by Initialing)	Other: (please explain)
_____ Alcohol/Drug Treatment _____ Mental Health Information _____ HIV-Related Information	_____ _____ _____

Please convey my documents by:

❏ Patient Pick Up	❏ Mail	❏ Fax	❏ Secure Email

Reason for release of information:

- ❏ At the request of the individual
- ❏ Other:_____
  This authorization will be in effect for one year from the date signed, unless you indicate a shorter period below:
- ❏ Date or event on which this authorization will expire:_____
- ❏ If an authorized representative is making this request, please provide your information below and attach certifying documentation of your status as the authorized representative, such as a Power of Attorney or Guardianship papers.

AUTHORIZED REPRESENTATIVE

Name:	Relationship:
Address:	DOB:
City:	State: Zip:
Phone: Fax:	Email

By signing this form, I am confirming that it accurately reflects my wishes. In addition, I have kept a copy of this form for my records.

_____

Signature of Patient or Authorized Representative Date