Questions?
Contact HealthMark Group at:
(800) 659-4035
status@healthmark-group.com

I AUTHORIZE *DE ORTHOPAEDIC SPECIALISTS* TO RELEASE THE FOLLOWING MEDICAL RECORDS INFORMATION

PATIENT INFORMATION:

Name: Date of Birth:

Email: Phone:

SELECT ONE OPTION FOR THE METHOD OF RELEASE OF YOUR INFORMATION

☐ **Receive Secure Email to Download Records (1 – 2 day delivery)** ☐ Fax:

☐ Mail* **(7 – 14 days delivery, dependent upon USPS)**

*Records exceeding 60 pages will be charged a fee of $15.00

PROVIDE "RELAEASE TO" CONTACT INFORMATION

☐ **Email Link To:** ☐ Fax To:

☐ Mail To This Address:

City: ST: Zip Code:

PROVIDE THIS INFORMATION ON THE RELEASE:

Dates of Service (Check One and Complete Dates of Service if Required)

☐ Please provide a complete copy of my file for service **from** _____ **through** _____

Records to be Released (45 CFR § 164.508(c)(1)(i)).

☐ Entire Chart ☐ Office Notes ☐ Consults ☐ Lab Reports ☐ Radiology Reports
☐ Imaging Films ☐ Medications ☐ Immunizations ☐ Operative Reports ☐ Physical Therapy
☐ Itemized Billing ☐ Other _____

Purpose for Disclosure

☐ Continuing Care ☐ Transfer of Care ☐ Referring Physician ☐ Disability
☐ Legal/Attorney ☐ Insurance ☐ Other _____

Please indicate your acceptance by checking the following boxes:

O I understand that I may revoke this authorization in writing at any time except to the extent that action has been taken in reliance upon this authorization (45 CFR § 164.508(c)(2)(i)).

O I understand that treatment or payment cannot be conditioned on my signing this authorization, except in certain circumstances such as for participation in research programs, or authorization of the release of testing results for pre-employment purposes (45 CFR § 164.508(c)(2)(ii)).

O I understand that my records are confidential and cannot be disclosed without my written authorization except when otherwise permitted by law. Information used or disclosed pursuant to this authorization may be subject to redisclosure by the recipient and no longer protected. I Understand that the specified information to be released may include, but is not limited to: history, diagnosis, and/or treatment of drug or alcohol abuse, mental illness, or communicable disease, including Human Immunodeficiency Virus (HIV) and Acquired Immune Deficiency Syndrome (AIDS) (45 CFR § 164.508(c)(2)(iii)).

This authorization will expire One Hundred Eighty (180) days from the date of my signature unless I revoke the authorization prior to that time.

Signature: _____ Date: _____

Reason if patient is unable to sign: _____
(Provide guardianship, executor of estate, death certificate, or power of attorney paperwork with request)