SOUTHWEST ORTHOPAEDIC GROUP®

HEALTH INFORMATION DISCLOSURE FORM

PATIENT NAME_____

DATE OF BIRTH_____ **SS NUMBER**_____

ADDRESS_____

CONTACT NUMBER_____

CONSENT TO RELEASE INFORMATION

I AUTHORIZE THE FOLLOWING INFORMATION TO BE DISCLOSED EITHER WRITTEN OR VERBALLY TO THE NAMED PARTY OR PARTIES BELOW FOR A PERIOD OF 180 DAYS DATED FROM THIS CONSENT UNLESS OTHERWISE NOTED BELOW. I UNDERSTAND THAT RELEASING THIS INFORMATION IS VOLUNTARY AND MAY BE REVOKED IN WRITING AT ANYTIME. I UNDERSTAND THAT A REVOCATION WILL NOT APPLY TO INFORMATION PREVIOUSLY RELEASED IN RESPONSE TO THIS AUTHORIZATION AND WILL NOT APPLY TO MY INSURANCE COMPANY IN THE EVENT OF A CONTESTED CLAIM. I, AS THE PATIENT UNDERSTAND THAT I HAVE THE RIGHT TO INSPECT AND OR COPY THE INFORMATION THAT IS TO BE DISCLOSED AND I ACKNOWLEDGE THAT WITH DISCLOSING HEALTH INFORMATION THERE IS A POTENTIAL FOR UNAUTHORIZED RE-DISCLOSURE THAT MAY NOT BE COVERED BY FEDERAL CONFIDENTIALITY LAWS.

INDIVIDUAL OR ORGANIZATION I WISH TO DISCLOSE MEDICAL INFORMATION TO:

_____

ADDRESS_____

CONTACT NUMBER_____ **FAX NUMBER**_____

***RELATIONSHIP IF ANY**_____

MEDICAL RECORDS REQUEST AUTHORIZATION

I UNDERSTAND THAT THE INFORMATION IN MY HEALTH RECORD MAY INCLUDE INFORMATION RELATING TO SEXUALLY TRANSMITTED DISEASE(S), AQUIRED IMMUNODEFICENCY SYNDROME (AIDS) OR HUMAN IMUNODEFIECENCY VIRUS (HIV). IT MAY ALSO INCLUDE INFORMATION ABOUT BEHAVIORAL OR MENTAL HEALTH SERVICES AND OR TREATMENT FOR ALCOHOL OR DRUG ABUSE. **AND BY INITALING HERE I CONSENT TO THE RELEASE OF THIS INFORMATION**_____

TEXAS REVISED CIVIL STATUE (ARTICLE 4495b, Sec. 5.08(j) REQUIRES THAT AN AUTHORIZATION OR REQUEST FOR MEDICAL RECORDS INCLUDE A REASON OR PURPOSE FOR THE RELEASE.

REASONS FOR RELEASE

☐ **CHANGE OF PHYSICIAN** ☐ **INUSRANCE** ☐ **LEGAL** ☐ **PATIENT MOVING** ☐ **PERSONAL USE** ☐ **OTHER:**_____

INFORMATION TO BE RELEASED **CHECK HERE FOR ENTIRE RECORD** ☐ **CHECK HERE FOR BILLING RECORDS** ☐

☐ **LAB REPORTS** ☐ **OPERATIVE REPORTS** ☐ **X-RAY/DIAGNOSTIC TESTING REPORTS** ☐ **FILMS** ☐ **OFFICE NOTE(S)**

DATE(S) TO BE SPECIFICALLY RELEASED_____

PLEASE SEND RECORDS TO **NAME:**_____

ADDRESS:_____

PHONE:_____ **FAX:**_____

I UNDERSTAND THAT THE INFORMATION RELEASED IS FOR THE SPECIFIC PURPOSE STATED ABOVE. ANY OTHER USE OF THIS INFORMATION WITHOUT WRITTEN CONSENT OF THE PATIENT IS PROHIBITED.

_____ **DATE**_____

PRINTED PATIENT NAME

X_____ **RELATIONSHIP TO PATIENT**_____

SIGNATURE OF PATIENT OR LEGAL REPRESENTATIVE

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