ORTHO SPINE AMERICA

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Request for Access to/Authorization for Use and Disclosure of Protected Health Information

PATIENT NAME ____________________

DATE OF BIRTH __/__/____ FORMER NAME ____________________ MEDICAL RECORD# ____________

ADDRESS ____________________ CITY ____________ STATE ____ ZIP ____________

DAY PHONE ____________________ EVENING PHONE ____________________

Type of access requested: ☐ Inspection ☐ Hard Copy ☐ Electronic Copy **(only available if SSM Health maintains the requested information electronically)**

I Hereby Authorize:

NAME	
ADDRESS	
CITY/STATE/ZIP	
PHONE	
FAX	

To Disclose My Protected Health Information To:

NAME	
ADDRESS	
Relationship	
CITY/STATE/ZIP	
PHONE	
FAX	

METHOD OF DELIVERY OF RECORDS *(please select one)*:

☐ Mail ☐ Hold for pick up by: ____________________

INFORMATION TO BE RELEASED *(DATES)*:

☐ Discharge Summary ____________
☐ History & Physical Exam ____________
☐ Progress Notes ____________
☐ Lab Reports ____________
☐ X-Ray Reports ____________
☐ Medication Records ____________
☐ Detailed Bill ____________
☐ Other (specify content and dates): ____________________

I specifically authorize the release of information relating to:

- Substance abuse (including alcohol/drug abuse)
- Mental health or behavioral health
- HIV related information (AIDS-related testing)

x ____________________

SIGNATURE OF PATIENT OR PERSONAL REPRESENTATIVE / DATE

PURPOSE OF DISCLOSURE:

☐ Changing physicians ☐ Consultation ☐ Insurance/Workers' Compensation ☐ School ☐ Research ☐ At request of individual

☐ Legal (specify): ____________________

☐ Other (specify): ____________________

☐ For personal access (specify): ☐ Copy ☐ Inspection ☐ Summary

ACKNOWLEDGMENT OF UNDERSTANDING:

- I understand that I may revoke this authorization at any time by notifying the providing organization in writing, and it will be effective on the date notified except to the extent action has already been taken in reliance upon it.
- I understand that information used or disclosed pursuant to this authorization may be subject to redisclosure by the recipient and no longer be protected by Federal or State privacy regulations.
- By authorizing this use or disclosure of information, there will be no conditions placed on my health care or payment for my health care.
- I understand that if I am being requested to authorize a use or disclosure that, upon request, I will get a copy of this form after I sign it.
- I understand my request will be acted upon within 30 days. If I am not provided access or information cannot be supplied, I understand I will be notified, and have the right to request review of any denial of access other than those made in accordance with applicable law.
- I understand that I may be required to pay the cost of creating paper copies or electronic media, mailing copies, supervising my inspection, or preparing a summary except for uses and disclosures for the purpose of treatment, payment, and operations.

I acknowledge and understand the terms of this **Request for Access to/Authorization for Use and Disclosure of Protected Health Information**.

Patient/Legal Representative Signature ____________________ **DATE** ____________

Relationship ____________________

Records Received by ____________________ **DATE** ____________ **ID VERIFIED** ____________