NAME _____ DATE OF REQUEST_____

DATE OF BIRTH _____ ACCOUNT # _____

# JEWETT ORTHOPAEDIC CLINIC
## AUTHORIZATION FOR USE OR DISCLOSURE OF MEDICAL RECORDS

As a patient or as an authorized representative of a patient of Jewett Orthopaedic Clinic, you are entitled to a copy of your medical records. You may also authorize release of your medical records to other recipients. You understand that when the information is used or disclosed pursuant to this authorization, it may be subject to re-disclosure by the recipient and may no longer be protected health information. When received by the medical records personnel, your identity will be verified and your request will be processed. If you have any questions or concerns, please contact the Director of Medical Records at 407-643-1286.

☐ I would like a **copy** of my medical records. I understand there may be a fee for these copies including any applicable postage fees. I understand that I will be required to pay the fee(s) in full before I may obtain the copies.

☐ Please send copies of my medical records to: ☐ By Mail ☐ By Fax ☐ Will Pick Up

Name _____ Phone#_____

Address _____ Fax# _____

_____ Pt. Phone# _____

**Description of Information to be copied (check all that apply)**

Medical data/information as related to:

- ☐ Specific condition(s) /specific physician(s):_____
- ☐ Specific time frame(s):_____
- ☐ All office notes, test results, and/or operative reports:_____
- ☐ Other:_____

Reason for request: ☐ Legal ☐ Insurance ☐ Medical Treatment ☐ Other_____

This authorization expires on [upon] _____ [Insert applicable date or event, i.e. - completion of treatment for this medical condition]

**I understand that I may inspect or obtain a copy of the information used or disclosed.**
**I understand that I may revoke this Authorization at any time by notifying the person/organization providing the information in writing, except to the extent that:**
**1. Action has been taken in reliance on the Authorization; or**
**2. If this Authorization is obtained as a condition for obtaining insurance coverage, other law provides the insurer with the right to contest a claim under the policy.**

**By signing below, I acknowledge and agree to the above conditions.**

**DATE** _____

_____ _____

**SIGNATURE OF PATIENT (OR AUTHORIZED REPRESENTATIVE*)** **PRINT NAME OF PATIENT (OR AUTHORIZED REPRESENTATIVE*)**

*Please explain Representative's relationship to Patient and include a description of Representative's authority to act on behalf of Patient.

_____

_____

**FOR OFFICE USE ONLY**

Identity Verification: ☐ Driver's license ☐Other ID # of Copies _____ @ $ _____ per copy $ _____ Total Cost
☐ Date Picked Up _____.☐ Date Faxed _____☐ Date Mailed _____ ☐Entered in Correspondence Log