

1225 Hancock Rd, Suite 105
Bullhead City, Arizona
86442
FAX: 928-758-5191



TRI STATE ORTHOPEDIC

AUTHORIZATION TO RELEASE PROTECTED HEALTH INFORMATION/MEDICAL RECORDS

Patient Name: _____ Date of Birth: _____

Address: _____

Phone: _____ Email: _____

I hereby authorize records from TRI STATE ORTHOPEDIC INSTITUTE to be released to:

Name: _____

Address: _____

Fax# _____ Phone: _____

Date Range: _____ to _____

To include: Office Notes Operative Reports Billing and Statements

For the purpose of:

Litigation Disability Medical Leave Self/Personal Copy

Continuity of Care (primary care/treating physicians) Insurance/Reimbursement

I understand that authorizing the disclosure and release of this health information is voluntary. I understand that any release of information carries with it the potential for unauthorized redisclosure, and the information may not be protected by federal confidentiality rules. I understand that transmission of data may be over unsecure fax or mail per my request.

I understand that the information in my medical record may include sensitive information about sexual, mental, behavioral, or social vices indicating diseases, treatments, and sensitive personal history. I understand that I have the right to revoke this authorization, but it will not apply to information that has already been shared. This agreement expires 1 year from the date signed.

I have read the information provided on this release and do hereby acknowledge that I am familiar with and fully understand the terms and conditions of my voluntary authorization to release my personal health information.

SIGNATURE OF PATIENT/GUARDIAN: _____ **DATE:** _____

_____ **(Initial) Administrative Fees:** All medical records and X-ray requests are subject to a base \$25 preparation fee, plus shipping and handling fees. Large volume medical records will incur the preparation fee plus \$0.25 cents per page to cover administrative costs. Prior to copying large files, our office will provide you with an estimate of fees that must be paid prior to release of records. Please allow up to 14 (fourteen) business/working days to complete any request. For continuity of care or patient personal copy, we may transfer or provide a minimal portion of your records as a courtesy. Large volumes, complete records, and radiological images will incur the fee.