Informed Consent

Medical Records Release

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AUTHORIZATION FOR RELEASE OF MEDICAL RECORDS

This form must be signed by the patient or person authorized by law.

Name: _____

Address: _____

City: _____ State: _____ Zip Code: _____

Date of Birth: _____ Social Security Number: _____

Other names (if applicable): _____

Transfer of original and duplicate records may be expedited by electronic means.

I, _____, permit Thomas Jeneby to release the records in Exhibit A. I agree to pay for all photocopying charges.

These records should be released to _____

_____[name and address of recipient] for the following purpose(s): _____

_____

_____

_____

.

I am aware that this authorization is my choice. It will not affect my treatment from Thomas Jeneby. I may take back this authorization, in writing, at any time. Disclosure may be made before I take it back. I understand that I may check and get copies of the information disclosed.

I understand that these records may be protected by the Federal Health Insurance Portability and Accountability Act ("HIPAA"). I am aware the recipient may re-disclose these records. In such a case, they may no longer be protected by HIPAA. My records may be protected under state law. They cannot be disclosed without written consent. It can only be disclosed if it is provided for in the law and/or regulations.

This authorization will not be valid one year from the date below. **My signature confirms that I have read, understood, and authorize the release of the information described in Exhibit A.**

_____ _____

Name Date/Time

 _____ **Patient Initials**

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This form is for reference purposes only. It is a general guideline and not a statement of standard of care. Rather, this form should be edited and amended to reflect policy requirements of your practice site(s), CMS and Joint Commission requirements, if applicable, and legal requirements of your individual states. The ASPS does not certify that this form, or any modified version of this form, meets the requirements to obtain informed consent for this procedure in the jurisdiction of your practice.

EXHIBIT A

DETAILS OF HEALTH INFORMATION THAT CAN BE RELEASED

By placing a check mark in the space below, I permit the release of the following records from _____ _____ to _____ [insert dates]:

___ Complete medical records
___ All hospital/institution records (nursing records/progress notes)
___ Hospital/institution records (surgical reports, history/physical exam reports, consultation reports, discharge summary)
___ Lab reports
___ Pathology reports
___ Imaging reports
___ EKG/cardiac reports
___ Physical/occupational therapy reports
___ Bills
___ Physician/clinical records
___ Implant details (including operative report)
___ Photos

Release of the following information may be governed by additional laws. I am aware and agree that this information will be disclosed only if I place my **initials** in the space below.

___ HIV/AIDS information
___ Mental health information
___ Genetic testing information
___ Drug/alcohol diagnosis, treatment, or referral information

 _____ **Patient Initials**
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