INOV8
Orthopedics

Authorization for Release of Radiographic Images
Pre-Payment is required

I hereby authorize the use and disclosure of my individually identifiable health information as described below.

Patient Name:_____
(Last) (First) (Middle / Maiden)

Date of Birth:_____ Telephone #: _____

Purpose of Disclosure: ☐ Medical Review ☐ Legal Review ☐ Insurance Review ☐ Personal Use ☐ Other_____

Radiology/Imaging:

☐ X-Rays Date(s): _____ to _____ Pertaining to: _____

Fees: Images can be placed on a CD at the cost of $8.00 Pre-payment. $7.35 postage fee applies for CD's (current USPS charge as of 2/18/19)

I authorize INOV8 Orthopedics to release the requested health information to:

Name/Organization: _____

Address: _____

City: _____ State: _____ Zip: _____

Telephone #: _____ Fax #: _____

Please allow 7-10 business days for your request to be completed.

Please check your preferred method for releasing the requested information:

☐ Mail to the address provided above. $7.35 postage fee applies for CD's and records 10+ pages (current USPS charge as of 2/1/18)

☐ I will pick up my CD at 10496 Katy Freeway, Ste 101 Houston Texas, 77043

☐ Email *(Free Service available only for X-Rays obtained after 8/1/18)* to the address below. **Failure to provide email address will void request**

_____

☐ I need to make other arrangements for picking up my medical records and or images.

Please note: *We will contact you for payment and/or to coordinate a designated date & time to pick up records.*

I understand that if the person or entity that receives this information is not a health plan or health care provider covered by federal privacy regulations, the released information may be re-disclosed by the recipient and may no longer be protected by federal or state law. I understand that I may revoke this authorization at any time by notifying the Inov8 and completing a revocation of personal representative form. However, if I choose to do so, I understand that my revocation will not affect any actions taken by INOV8 before receiving my revocation. I understand that I may refuse to sign this authorization and that my refusal to sign in no way affects my treatment, payment, enrollment in a health plan or eligibility for benefits. *I understand that the information in my medical record may include information relating to treatment for drug or alcohol abuse, sickle cell anemia, psychological or psychiatric impairments, sexually transmitted disease, acquired immunodeficiency syndrome (AIDS), and AIDS related complex (ARC) and/or human immunodeficiency virus (HIV). This authorization will expire in 90 days, unless otherwise noted.

Signature:_____ Date:_____
(Patient/Minor/Emancipated Minor or Authorized Representative – Relationship: ☐ Spouse ☐ Parent ☐ Other:_____)

*****Please note: the information following the asterisk above applies to minors as well as emancipated minors
Signature of Minor / Emancipated Minor:_____