INOV8 Orthopedics

Account #_____
Date: _____

10496 Katy Freeway, Ste 101 Houston Texas, 77043 Ph (346) 571-7500 / Fax (713) 492-2440

Authorization for Use/Disclosure of Protected Health Information Form

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

Patient Name:_____
(Last) (First) (Middle / Maiden)
Social Security #: ___ ___ ___-___ ___-___ ___ ___ ___ Date of Birth: ___ ___ / ___ ___ / ___ ___ __ ___

Telephone #: ___ ___ ___ / ___ ___ ___ / ___ ___ ___ ___ Cell/Work #: ___ ___ ___ / ___ ___ ___ / ___ ___ ___ ___

Medical Records: Please check the specific information to be released/disclosed and the related date(s) of service:

☐ Clinical Notes ☐ Test Results ☐ Operative Note ☐ Medication List ☐ Work Status Form ☐ Itemized Bill ☐ PT Notes
☐ Other: _____
Date(s): _____ Pertaining to: _____

Fees: The ***minimum*** fee is $25.00 per request

Radiology/Imaging: Please check the specific radiographic images to be released/disclosed and the related date(s) of service:

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

Fees: Images will be provided to you on CD at the cost of $8.00 Pre-payment.

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

I authorize INOV8 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:
☐ Fax to the number provided above
☐ Mail to the address provided above. $6.70 postage fee applies for CD's and records 25+ pages (current USPS charge as of 2/1/18)
☐ I will pick up my medical records at 10496 Katy Feeway, Ste 101 Houstan Texas, 77043
☐ 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:_____