INOV8
Orthopedics

Authorization to Obtain Health Information

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 #: _____

Please list the related date(s) of service and check the specific information to be released:

Date from: _____ Date to: _____ Pertaining to: _____

☐ All records ☐ Diagnostic Test Results _____ ☐ Other_____

I authorize the individual or organization listed below to release the requested health information to **INOV8 Orthopedics** for the purpose of continued medical review/treatment.

Name/Organization: _____

Address: _____

City: _____ State: _____ Zip: _____

Telephone #: _____ Fax #: _____

Please check your preferred method for releasing the requested information:

□ Mail the information to: **INOV8 Orthopedics**

Attention: _____
10496 Katy Fwy, Ste 101
Houston, TX 77043
Tel: 346-571-7500 | Fax: 713-492-2440

□ Fax the information to Inov8 Orthopedics fax # 713-492-2440

□ I will pick up the information or someone will pick it up for me.
Individual's Name: _____ Relationship: □ Spouse □ Parent □ Child □ Other_____

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: _____

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