UNIVERSITY ORTHOPEDICS
Healers. Innovators. Teachers.

AUTHORIZATION FOR THE RELEASE OF INFORMATION

Section A: U.S. GOVERNMENT REGULATIONS REQUIRE THIS FORM BE COMPLETED AND SIGNED BEFORE ANY MEDICAL RECORDS WILL BE RELEASED AND RETAINED ON FILE FOR 7 YEARS.

I hereby authorize the use or disclosure of my individually identifiable health information as described below. I understand that this authorization is voluntary. I understand that if the organization authorized to receive the information is not a health plan or a health care provider, the released information may no longer be protected by federal privacy regulations.

Patient Name: _____ **Date of Birth:** _____ **ACCOUNT #:** _____

Address: _____ **Phone #:** _____

Persons/organizations providing the information:

UNIVERSITY ORTHOPEDICS, INC

1 KETTLE POINT AVE

EAST PROVIDENCE, RI 02914

Provider/ Department Name:

Persons/organizations authorized to receive information:

_____

_____

Specific information REQUESTED including dates:

_____
_____
_____
_____

Purpose of disclosure:

_____

OR IF APPLICABLE:
circle: ENTIRE MEDICAL RECORD

Section B: Must be completed for all authorizations: Please check one**:** I hereby ___CONSENT ___REFUSE to the release of protected health information concerning: Mental Health, Alcohol and/or drug use, sexual abuse, sexually transmitted diseases, AIDS or HIV test results. *(These may or may not be part of your record at University Orthopedics.)*

Section C: Must be completed for all authorizations:

The patient or the patient's representative must read and initial the following statements:

I understand that this authorization will expire one year from the date below. Initials: _____

I understand that *I may revoke this authorization* at any time by notifying the providing organization in writing, but if I do, it won't have any effect on any actions taken prior to the date of revocation. Initials: _____

Signature of patient or patient's representative (Power of Attorney must be on record)

_____ **Date:** _____

Printed name of patient or patient's representative: _____

Relationship to patient (if applicable): _____

YOU MAY REFUSE TO SIGN THIS AUTHORIZATION