ADVANCED
Orthopaedics & Rehabilitation

100 Trich Drive, Suite 2
Washington, PA 15301
724-225-8657
Fax: 724-228-8388
800-828-2278 (CAST)

AUTHORIZATION FOR PROTECTED HEALTH INFORMATION

Patient Name_____ Date of Birth_____

Address_____ City _____ State_____ Zip _____

Social Security Number_____ Phone_____

I HEREBY AUTHORIZE Advanced Orthopaedics & Rehabilitation TO: ☐ RELEASE TO OR OBTAIN FROM ☐

Name of Doctor/Hospital/Facility_____

Address_____ City _____ State_____ Zip _____

Fax Number _____

Records are requested for the purpose of continuation of medical treatment, payment of bill, workman's comp, other education, self, legal or insurances purposes **PLEASE PROVIDE DETAILED DESCRIPTION**_____

(Records will not be released if this is left blank)

Information to be Disclosed

Hospitalizations	**Dates**	**Outpatient Visits**	**Dates**	**Other**	**Dates**
Discharge Summary		Progress Notes		Complete Health Record	
History & Physical		Diagnosis		Electronic Health Information (USB)	
Laboratory		Laboratory		Other, specify:	
Consultation		Radiology Reports		X-Ray Films/CD	
Operative Report		Itemized Bills		Body Part	

Advanced Orthopaedics & Rehabilitation requires $5.00 charge for a digital copy(CD) of all x-ray images. A $20.00 deposit is required for the release of actual films. Since actual films are a permanent part of your medical record, films must be returned within 30 days, and the $20.00 deposit will be returned by check.
A $45.00 charge is required for all information requested on a USB drive.

• This authorization will expire one year from the date of your last signature below, unless you specify an earlier termination. You must renew or submit a new authorization after the expiration date to contiue the authorization. Please list the date of expiration if earlier than one year_____

• You have the right to terminate this authorization at any time by submitting a written request to our Privacy Manager. Termination of this authorization will be effective upon written notice, except where a disclosure has already been made based on prior authorization.

• The practice places no condition to sign this authorization on the delivery of healthcare or treatment.

• We have no control over the person(s) you have listed to receive your protected health information. Therefore, your protected health information disclosed under this authorization may no longer be protected by the requirements of the Privacy Rule, and will no longer be the responsibility of the practice.

You have the right to receive a copy of signed authorizations upon request.

FOR OFFICE USE ONLY

Fees	Paid
CD $5.00	
EHI $45.00	
Films $20.00	

When Films are Returned,
Print from SRS and give to Billing

Date Returned _____
Staff Signature _____
Patient Signature _____

_____
Signature of Patient or Legal Representative Date

_____
Signature of Parent, Legal Guardian or Legal Representative Date

_____
Signature of Witness/Staff Member Date