

Greater Chesapeake Hand Specialists, P.A.
AUTHORIZATION For RELEASE OF MEDICAL INFORMATION
(PLEASE PRINT)

Patient Name: _____ Date of Birth: ____ / ____ / ____

Patient Address: _____ SSN #: _____ - _____ - _____

City: _____ State: _____ Zip Code: _____ Phone number: _____

I hereby authorize Greater Chesapeake Hand Specialists, P.A. ("GCHS") to release my Protected Health Information to: (Insert complete address)

Name: _____
(Physician, Attorney, Hospital, Agency, etc.)

Street Address: _____

City: _____ State: _____ Zip Code: _____

Fax # (faxes will only be sent when 25 pages or less are copied) _____

Check Protected Health Information to be disclosed:

<input type="checkbox"/> DISCHARGE SUMMARY	<input type="checkbox"/> OPERATIVE NOTES	<input type="checkbox"/> PATHOLOGY REPORTS
<input type="checkbox"/> HISTORY & PHYSICAL	<input type="checkbox"/> LABORATORY REPORTS	<input type="checkbox"/> BILLING STATEMENTS
<input type="checkbox"/> PROGRESS NOTES	<input type="checkbox"/> RADIOLOGY REPORTS	_____

I Do Not	I Do	Authorize release of information related to:
_____	_____	AIDS (Acquired Immunodeficiency Syndrome) or HIV (Human Immunodeficiency Virus) Infection
_____	_____	Alcohol and/or Drug Abuse
_____	_____	Sexually Transmitted Diseases

PURPOSE OF DISCLOSURE:

<input type="checkbox"/> REFERRAL TO SPECIALIST	<input type="checkbox"/> INSURANCE	<input type="checkbox"/> WORKERS COMP
<input type="checkbox"/> LEGAL INVESTIGATION	<input type="checkbox"/> DISABILITY DETERMINATION	<input type="checkbox"/> PERSONAL
<input type="checkbox"/> Other Please Describe _____		

I understand that I have the right to revoke this authorization at any time. I understand that my revocation must be in writing and addressed to the Privacy Officer of GCHS authorized to make this disclosure. I understand that the revocation does not apply to information already released in response to this authorization.

Unless otherwise revoked, this authorization will expire six months from the date from which it was originally signed or on the following date: _____

I understand that any disclosure of information may be subject to re-disclosure by the recipient and may no longer be protected by federal or state law. I understand that I need not sign this authorization to assure treatment. I understand that I may inspect and/or copy the information to be disclosed. I understand that authorizing this disclosure is voluntary. I understand that if I have questions about disclosure of my health information, I may contact the Privacy Officer at GCHS or request a copy of this authorization.

Signature of Patient or Authorized Representative

Date

Fees for Copies: Federal and state laws permit a fee to be charged for the copying of patient records. You may be required to pre-pay for the copies; if not, then copies will be mailed along with an invoice.