AUTHORIZATION FOR RELEASE OF PROTECTED HEALTH INFORMATION

All sections must be completed or form will be returned.
Requests take approx. 5-8 business days to process and rush requests cannot be honored. Staff cannot complete blank sections or change information on the form.
Questions? Call 513-354-3736. Fax form to: 513-354-3705.

PATIENT INFO: Name: _____ **Date of birth:** _____

Address: _____

Phone: _____ Reason for request: _____

INFORMATION TO BE RELEASED: I hereby request and authorize OrthoAlliance (and its affiliates) and Beacon Surgery Center to release the protected health information indicated below. I understand and acknowledge that this may include treatment for physical and mental illness, alcohol/drug abuse, and HIV/AIDS test results or diagnoses.

Mark all that apply. Fill in both the dates of treatment *and* check off what records are to be released.

1. DATES OF TREATMENT TO RELEASE (MONTH & YEAR): From _____ to _____
2. Please release:

(mark all that apply)

____Office Visit Notes	____Imaging Reports	____Operative Reports	____MRI Images
____Lab Results	____Procedure Notes	____Itemized Billing	____Xray Images
____Physical Therapy	____EMG Report		
____Other (be specific) _____			

RELEASE INFORMATION TO: Fill in first line – then select ONE of the three options. Images cannot be faxed. Mailed items take additional time to be received via USPS after the initial processing time. If you request that records be emailed, check your spam/junk folder - records may go there because they are sent using encryption software to protect your information.

Provider and Practice/Person/Company: _____

1. Mail to: Address: _____

   City/ST/Zip: _____
2. Fax Number: _____
3. Email Address: _____

EXPIRATION, PATIENT RIGHTS AND FEES: This authorization will expire one year from the date signed below (unless I specify an earlier date here: _____). I understand I may revoke this authorization at any time, in writing, and that revocation will not apply to information that has already been released. Information used or disclosed as per this authorization may be re-disclosed by the provider/ place/person receiving the information and may no longer be protected by federal or state law. Signing this authorization is voluntary. I can refuse to sign this authorization. My right to health care treatment is not conditioned on this authorization. I understand that I may request a copy of this authorization, that there may be a charge for the requested information, and that information sent via unencrypted email could be read by a third party.

SIGNATURE: Please sign – do not type in a "signature."

X_____ _____

Signature of Patient or Legally Authorized Representative* Date

_____

*IF APPLICABLE: Printed Name and Relationship of Legally Authorized Representative. If patient is over the age of 18, you must also provide appropriate documentation such as copy of Medical Power of Attorney or court order with request.

Updated July 2024 *Dated request processed:* _____ *By:* _____