Authorization for Use/Disclosure of Protected Health Information Form

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 #: ______________________

Purpose of Disclosure: ☐ Medical Needs ☐ Legal Review ☐ Insurance Review ☐ Personal Use ☐ Other______________

Medical Records: Please check the specific information to be released/disclosed and the related date(s) of service:

☐ Clinical Notes ☐ Test Results ☐ Operative Note ☐ Medication List ☐ Work Status Form ☐ Itemized Bill ☐ PT Notes ☐ Entire Chart
☐ Other: ____

Record(s) from ________________ to ________________ Pertaining to: ________________

Fees: The ***minimum*** fee is $25.00 per request ($25.00 paid in advance).

Radiology/Imaging/Xray:

☐ X-Rays Date(s): ________________ to ________________ Pertaining to: ________________

Fees: Xray images placed on a CD at the cost of $8.00 ($8.00 paid in advance). Xrays emailed at no cost.

I authorize INOV8 Orthopedics to release the requested health information to:

Name/Organization: ____

Address: ____

City: ________________ State: ________________ Zip: ________________

Telephone #: ________________________ Fax #: ________________________

Please allow 7-10 business days for your request to be completed. (*Texas State Board of Medical Examiners allows 15 business days)*
Please check your preferred method for releasing the requested information:
☐ Fax to the number provided above
☐ Mail to the address provided above. (applicable postage applies)
☐ I will pick up my medical records at 10496 Katy Freeway, Ste 101 Houston Texas, 77043
☐ Email (Service available only for X-Rays **ONLY**) to the address listed here: ________________________
☐ I need to make other arrangements for picking up my medical records and or images.
Please note: *We will contact you for payment and/or to coordinate a designated date & time to pick up records.*

I understand that if the person or entity that receives this information is not a health plan or health care provider covered by federal or state privacy laws, 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 INOV8 in writing at the address listed below. However, I understand that my revocation will not affect any actions taken by INOV8 before receiving my written notice of 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. Except as otherwise expressly provided herein, this authorization will automatically expire upon the earlier of 90 days after the date noted below or upon my express written notice of revocation to INOV8. *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).

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: ______________________________