Authorization to Disclose Health Information

TUCSON ORTHOPAEDIC INSTITUTE

I, the undersigned, authorize:
Tucson Orthopaedic Institute
P.O. Box 31630
Tucson, AZ 85751-1630
Fax: (520) 784-6445

Patient Infomation

Patient Full Name: _____ Other Names During Treatment? _____

Patient Address: _____ Date of Birth: _____

City: _____ State _____ Zip: _____ Phone #: _____

Release Information To

Patient's Identification Verified *-This box must be complete in order for request to be processed-*

Name/Facility: _____ Attention: _____

Address: _____ Phone: _____

City: _____ State _____ Zip: _____ Fax: _____

Purpose of Request: ☐ Personal ☐ Treatment ☐ Legal ☐ Insurance ☐ Disability
☐ Transfer/Reason _____ ☐ Other _____

Information to be Released

Section 1:
Charges for person requests

Complete Medical Record	$6.50
Complete chart on CD	$5.00
Images on CD	$5.00

For doctor to doctor requests, there will be no fee. By default, the past two years of pertinent information will be sent. Please provide any specific additional information in Section 2: →

Section 2:
Please provide information in my medical record for dates:
From_____**To**_____

Pathology Reports
☐ History and Physical Examination
☐ Office Visit Note
☐ Laboratory Tests
☐ X-Rays/Imaging Reports
☐ Billing
☐ Images on CD

Form of Records

Please choose:
☐ Records on Paper ☐ Images ☐ Mail to Patient
☐ Records on CD ☐ Patient will pickup

Authorization to Release Protected

***Required** - Please complete the check boxes below indicating how protected information should be handled even if the categories do not necessarily apply to the patient's medical records.

Check one *Initial each line below*

I ☐ **DO** ☐ **DO NOT** want information about ***Mental Health** released _____
I ☐ **DO** ☐ **DO NOT** want information about ***HIV Tests** & **Related Information** released _____
I ☐ **DO** ☐ **DO NOT** want information about ***Alcohol and/or Substance Abuse** released _____
I ☐ **DO** ☐ **DO NOT** want information about ***Communicable Diseases** released _____

STOP Please confirm that you have put a checkmark and initialed all the protected information categories above regardless if they are applicable or not. If form is incomplete, or if protected information is not released, we may be unable to fulfill this request.

Patient's Signature_____**Date:**_____
(Required for all patients 18 years and older. 18 years and older for psychiatric records, 12 years and older for substance abuse records)

Signature of Parent or Legal Guardian_____**Date:**_____
(Required for all patients under the age of 18 unless otherwise allowed by law. If not the parent, legal representation documentation must be supplied)

- *This authorization will expire 90 days from the date appearing above. I understand that I may revoke this authorization at any time by notifying the Health Information Management Department in writing, but if I do, it will not have any effect on the actions the hospital took before it received the revocation.*
- *I understand that under the applicable law the information used or described pursuant to this authorization may be subject to redisclosure by the recipient and no longer subjectto the protections of the privacy standard.*
- *I understand that my treatment or continued treatment by Tucson Orthopaedic Institute and its affiliates is no way conditioned on whether or not I sign the authorization and that I may refuse to sign it.*
- *I understand that I may inspect or copy the information that is used or disclosed.*

Patient's Identification Verified - Initals of TOI Staff: _____