

Baton Rouge Orthopaedic Clinic

Authorization for Release of Medical Records Must be Completed

I hereby authorize Baton Rouge Orthopaedic Clinic to use or disclose the following protected health information (PHI) from the medical records of the patient listed below to:

Requested By: _____

Address: _____

Patient Name: _____

Patient DOB: _____

Patient SSN: _____

Patient Address: _____

Disclose the following PHI for treatment dates _____ to _____.

History & Physical Progress Notes Consult
 Physician Orders X-Ray Report Nurses Notes
 Chart Notes Other Specify MRI Results*
*If Applicable

The above information is disclosed for the following purpose(s):

Another physician Legal Insurance Personal Other

____ I acknowledge, and hereby consent to such, that the released information may contain alcohol and drug abuse, psychiatric, HIV or genetic information.

This authorization shall expire upon this expiration date: _____

***If a specified date is not entered the authorization will expire in six (6) months from the date form is signed.

- I understand that I have the right to revoke this authorization at any time and must do so in writing to BROCC. I understand that this revocation will not apply to information that has already been released pursuant to the authorization.
- The information used or disclosed pursuant to the authorization may be subject to redisclosure by the recipient and no longer protected.
- My treatment, payment, enrollment or eligibility for benefits may not be conditioned on signing this authorization.

I have read the above and authorize the disclosure of the protected health information as stated.

Signature of Patient/Legal Guardian

Date

Witness

Date