Quality Orthopaedic Care, P.C.

H. James Forbes, MD, F.A.A.O.S.
Scott R. Devanny, MD, F.A.A.O.S.
Robert S. Cummings, Jr., MD, F.A.A.O.S.
David C. Molind, PA-C, M.H.P., P.T.

AUTHORIZATION FOR RELEASE OF PROTECTED HEALTH INFORMATION

Patient Name: ___________________________________ Date of Birth: _______________

___ Please send a copy of my records to Quality Orthopaedic Care (address provided below)

___ Please release my Quality Orthopaedic Care records to:

____

____

____

(please indicate all or specific records to be released)

___ All records ___ Office notes ___ X-rays

___ Notes/letters/radiology reports from third party facilities

___ Admission/discharge/operative reports from third party facilities

___ Other ____

I understand that my permission to release this information to the above entity will include sensitive clinical information obtained during the course of providing treatment. This information may or may not include treatment of substance or other abuse, HIV, sexually transmitted diseases, etc. This protected health information is being used and disclosed to carry out treatment, payment and/or health care operations of the facility in the following manner: To coordinate healthcare treatment with another facility and share information between entities to provide healthcare and/or to disclose necessary information to insurance companies and/or entities in order to obtain payment for services rendered in the course of operations.

This authorization shall be in force and effect for one year at which time this authorization to use or disclose this protected health information expires. I understand that I have the right to revoke this authorization, in writing, at any time by sending such written notification to the facility where this release is in effect. I understand that a revocation is not effective to the extent that the facility has relied on the use or disclosure of the protected health information.

I understand that information used or disclosed pursuant to this authorization could be subject to redisclosure by the recipient and, if so, privacy of this information may no longer be protected by federal or state law. Quality Orthopaedic Care, P.C. will not condition my treatment, payment, enrollment (if applicable) in a health plan or eligibility for benefits on whether I provide authorization for the requested use or disclosure. I understand that I have the right to refuse to sign this authorization.

I, (patient listed above or guardian of patient), hereby authorize your office to use and/or disclose the protected health information described above.

____ ____________________

Signature of patient or parent/guardian Date

Memorial Building, Suite 106
246 Pleasant Street, Concord, NH 03301
Phone: 603-224-1223 Fax: 603-228-7133