Ozark Orthopaedics
Specializing in You

Incomplete or illegible forms will not be processed

AUTHORIZATION TO RELEASE OR OBTAIN MEDICAL INFORMATION

Patient Name: _____

Birthdate: _____ SS#: _____ Phone: _____

Address: _____ City,ST,Zip: _____

I hereby authorize Ozark Orthopaedics to **RELEASE information to**:
Name of Facility or Person
Address
City, State, Zip
Phone/Fax

I hereby authorize Ozark Orthopaedics to **RECEIVE information from:**
Name of Facility or Person
Address
City, State, Zip
Phone/Fax

Purpose of Use/Disclosure: _____

Information/Type of Records to Be Released: ☐ Entire chart

Dates of Service: _____ ☐ Specific information: _____

_____

- This authorization will expire one year from the date signed unless you specify an earlier termination. You must submit a new authorization form after the expiration date to continue the authorization.
- You have the right to terminate this authorization at any time by submitting a written request to our Privacy Manager. Termination of this authorization will be effective upon written notice, except where a disclosure has already been made based on prior authorization.
- The practice places no condition to sign this authorization on delivery of healthcare or treatment.
- We have no control over the person(s) you have listed to receive your PHI. Therefore, your PHI disclosed under this authorization may no longer be protected by the requirements of the Privacy Rule, and will no longer be the responsibility of the practice.

I understand that the information authorized for release may include records which indicate the presence of communicable or non communicable diseases including, but not limited to, hepatitis, AIDS, as well as mental health information, and/or records concerning treatment for alcohol and/or drug abuse.

_____ _____

Signature of Patient or Legal Representative **Date**

_____

Relationship to Patient/Description of Legal Authority

A copy of this authorization must accompany released information

Please allow a minimum of 7-10 days for processing

Thank you for choosing Ozark Orthopaedics

OFFICE USE ONLY:

Request received by: _____

Date received: _____

Processed by: _____

Date Processed: _____

Mail completed form to: **Ozark Orthopaedics, Medical Records, 3317 N Wimberly Dr., Fayetteville, AR 72703,**

fax completed form **to: 479-443-7862 or email** to **medicalrecords@ozarkorthopaedic.com**