FOR RECORDS TO BE RELEASED TO **A THIRD PARTY**

Incomplete Forms Cannot Be Accepted or Processed and will be returned for completion

Patient Request to Release Records from Ozark Orthopaedics

Patient Name: _____ **DOB:** _____

Patient Address: _____

_____

Patient Phone: _____ **e-mail:** _____

Information to be released: **If Entire Chart is selected, do not check any other boxes in this section**

- ☐ Clinic Notes
- ☐ Operative Report
- ☐ MRI Report
- ☐ Other: _____
- ☐ Imaging on CD (MRI/X-rays)
- ☐ Entire Chart (No imaging CD)
- ☐ Entire Chart (With imaging CD)

Note: ALL imaging is produced on CD

Purpose of Disclosure:

- ☐ Medical Care
- ☐ Insurance
- ☐ Other: _____
- ☐ Attorney
- ☐ Personal use

RELEASE INFORMATION TO: _____

FULL ADDRESS: _____

_____

_____

PHONE NUMBER: _____

FAX NUMBER: _____

WE WILL NOT RELEASE INFORMATION WITHOUT THIS COMPLETED SECTION

Please see page 2 for acknowledgements and disclaimers before signing this authorization

☐ I have read and understand acknowledgements and disclaimers.
I understand that ***this request will not be processed if this box is not checked.***

_____ _____

Signature of Patient or Legal Representative **Date**

_____

Relationship to Patient/Description of Legal Authority

A copy of this authorization must accompany released information

Please **mail** completed form to:

Ozark Orthopaedics, Medical Records, 3317 N Wimberly Drive, Fayetteville, AR 72703

E-mail form to: medicalrecords@ozark-ortho.com **Fax** form to: 479-443-7862

Acknowledgements and Disclosures

Warning and Assumption of Risks: Although all records sent via email are encrypted, Ozark Orthopaedics does not guarantee information sent via email is secure. There are security risks associated with emailing information, including, but not limited to, an unauthorized person or entity accessing or using the information. By requesting that

This authorization shall be deemed to expire on the earlier of one (1) year from the date set forth next to my signature within a reasonable time following completion of the event which gave rise to the purpose of this Authorization, unless I terminate this Authorization any time by submitting a written request to Ozark Orthopaedics .

Ozark Orthopaedics places no condition to sign this authorization on delivery of healthcare treatment.

Ozark Orthopaedics has no control of the information once released to the patient or the patient's representative. 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 Ozark Orthopaedics.

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 substance use disorder.

Under the HIPAA Privacy Rule, a covered entity must act on an individual's request for access no later than **30 calendar days after receipt of the reques**t. If the covered entity is not able to act within this timeframe, the entity may have up to an additional 30 calendar days, as long as it provides the individual – within that initial 30-day period – with a written statement of the reasons for the delay and the date by which the entity will complete its action on the request. **See 45 CFR 164.524(b)(2).**

Office Use Only

Accepted By:	**Date Received and Accepted:**
Request Processed By:	**Date Processed:**