MIDTOWN ORTHOPEDICS

PATIENT REQUEST FOR ACCESS TO PROTECTED HEALTH INFORMATION

Notice to Patient: Your request for access to your protected health information is only applicable to the information maintained by Midtown Orthopedics and Sports Medicine clinic/Dr. Jason Emerson. If you would like health information from another provider/facility you must submit a request to that provider. **We do NOT email medical records.**

PATIENT NAME:_____

DOB:_____ SOCIAL SECURITY #_____

ADDRESS:_____

CITY:_____ STATE:_____ ZIP_____

PHONE NUMBER:_____ EMAIL:_____

RELEASE FROM: I hereby request a copy of protected health information in my health records at MIDTOWN ORTHOPEDICS from (date)_____ to (date)_____

to be released to: ☐ myself ☐ Attorney (name)_____

☐ personal representative (name/relationship)_____

Please mail a copy to: myself at (address)_____

I understand:

The information authorized for release may include records which may indicate the presence of a communicable disease or a non-communicable disease. The information may include health information related to drug or alcohol abuse or Mental Health. Which is covered by Federal confidentiality rules. The federal rules prohibit anyone receiving this information or records from making further release unless it is expressly permitted by written authorization of the person to whom it pertains or as otherwise permitted. A general authorization for the release of medical or protected health information is not sufficient for this purpose. The Federal rules restrict any use of the information to criminally investigate or prosecute any alcohol or drug abuse patient. As a result by signing below I specifically authorize any such records to be included in my health information records to be released.

I will be charged $1.00 for the first page and $0.50 for each additional page plus postage if mailed.

Patient Signature:_____ DATE:_____