THE ORTHOPEDIC PARTNERS
AN RCM CLINIC

Authorization for Protected Health Information

Name of Patient: _____

Address: _____ City: _____ State: _____ Zip: _____

Phone #: _____ Social Security #: _____ Birth date: _____

Relationship to Patient if not self: _____

I authorize access of my information to the following: Please include Name, Address, City, State, Zip, phone number, and relation to patient.

1.	2.	3.
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____

MEDICAL DATA/INFORMATION

- ❑ Whole Chart
- ❑ History & Physical
- ❑ Most Current Visit with Lab & X-ray
- ❑ Pathology
- ❑ Lab Reports
- ❑ EKG
- ❑ Radiology Reports
- ❑ Psychiatric Records
- ❑ Dates & Times of Appointments
- ❑ Alcohol/Drug Treatment Records
- ❑ Infectious Disease
- ❑ Other: _____

This authorization shall be in force and effect until_____(effective 180 days from date signed unless otherwise specified).

A specific expiration date is required. Please note the following examples are NOT acceptable expiration dates: "No expiration date", "Forever" and/or "Death".

I understand that I have the right to revoke this authorization, in writing, at any time by sending such written notification to The Orthopedic Partners at 900 Round Valley Drive #100, Park City, UT 84060. I understand that a revocation is not effective to the extent that my physician has relied on the use or disclosure of the protected health information or if my authorization was obtained as a condition of obtaining insurance coverage and the insurer has a legal right to contest a claim.

I understand that information used or disclosed pursuant to this authorization may be disclosed by the recipient and may no longer be protected by federal or state law.

My physician will not condition my treatment, payment, enrollment in a health plan or eligibility for benefits (if applicable) on whether I provide authorization for the requested use or disclosure except (1) if my treatment is related to research, or (2) health care services are provided to me solely for the purpose of creating protected health information for disclosure to a third party.

Signature of Patient or Legal Guardian:_____Date: _____

A representative from The Orthopedic Partners may call to confirm the receipt of request.