OLYMPIA ORTHOPAEDIC ASSOCIATES
PO Box 368 Olympia, WA 98507
www.olyortho.com

FAX BACK (360)786-9010

Authorization for Release of Information

Completion of this document authorizes the disclosure and/or use of individually identifiable health information, as set forth below, consistent with Federal law concerning the privacy of such information. Failure to provide all information requested may invalidate this authorization. This form may not be used to simultaneously release psychotherapy notes with other types of health information.

Patient Information

Last Name _____ **First** Name _____

Date of Birth ____ / ____ / ____ Previous name(s) used by patient _____

Information to be Released to:

☐ I would like my records mailed to the address below ☐ My records will be picked up by the person named below

Name _____ Phone (____) _____ - _____

Address _____

City _____ State _____ Zip _____

Information to be Released:

☐ Imaging Please specify Date Range, Body Part or "All": _____

Please note that an imaging result does not provide a diagnosis. In order to receive a diagnosis and treatment, you must be evaluated by your physician.

→ ☐ Report Only

→ ☐ Images on Disk + Report - ***Patients will incur a $10 charge for imaging provided on disk***

☐ Chart Notes Please specify Date Range, Body Part or "All": _____

☐ Billing Statement Please specify Date Range, Body Part or "All": _____

☐ Other (specify) Please specify Date Range, Body Part or "All": _____

Restrictions: State law may prohibit recipients of your health information from making further disclosure of your health information unless that individual or entity obtains another authorization from you, or unless such disclosure is specifically required or permitted by law. *However, If you have authorized the disclosure of your health information to someone who is not legally required to keep it confidential, it may be re-disclosed and may no longer be protected.*
Patient Rights: You may revoke this authorization at any time. Your revocation must be in writing, signed by you or on you behalf and delivered to this office at the address at the top of this form. Your revocation will be effective upon receipt, but will not be effective to the extent that the recipient of your information or others have acted in reliance upon this authorization. You have a right to receive a copy of this authorization.

Signature _____ **Date** _____

Relationship to Patient if other than self: _____