SUMMIT
HOME CARE & HOSPICE

AUTHORIZATION FOR RELEASE OF MEDICAL INFORMATION

PATIENT'S NAME: _____

SOCIAL SECURITY NO.: _____

DATE OF BIRTH: _____

I hereby authorize Summit Orthopaedic Home Care to release the information requested below to the following person or entity identified below. My health care provider has authority to discuss my protected health information with the person identified, as well as to produce any records requested. The purpose of this authorization is for

_____.

Name (of person or entity authorized to receive information):

_____

Address: _____

_____

Phone Number: ( ) _____ Fax Number: ( ) _____

INFORMATION REQUESTED:

_____ Therapy records

_____ Billing Records

_____ Other (Please specify): _____

For the time period from:

_____/_____ /_____ (mm/dd/yyyy) to _____/_____ /_____ (mm/dd/yyyy)

- I understand that I may be charged reasonable cost-based fees as allowed by law, for all postage and copying costs and other agreed-upon special services.
- I understand that information disclosed pursuant to this authorization may be redisclosed and may no longer be protected by the federal privacy requirements, including HIPAA, 45 C.F.R., part 164.
- This authorization permits the release of information which may be related to a sexually transmitted disease, acquired immunodeficiency syndrome (AIDS), human immunodeficiency virus (HIV), behavioral or mental health services and/or treatment for alcohol and/or drug abuse.
- I understand that I have the right to revoke this authorization at any time by sending a written revocation to Summit Orthopaedic Home Care, but that this authorization cannot be revoked to the extent that protected health information has been previously provided in reliance on this document.
- Summit Orhtopaedic Home Care may not condition treatment, payment, enrollment or eligibility for benefits if I refuse to sign this authorization.
- A copy of this authorization may be used as an original. This authorization may remain valid for a maximum period of one year following the signature date.
- I have a right to receive a copy of this authorization.

_____ _____

Date Signature of Patient or Legal Representative

_____

Printed Name

_____

Legal Relationship to Patient (*Please attach documentation in support of authority*)

Return by fax (614) 866-8160 or by email medicalrecords@summit-ortho.com

Please allow up to 30 days for requests to be processed.