ORTHOPAEDIC ASSOCIATES OF SOUTHERN DELAWARE, P.A.
17005 OLD ORCHARD ROAD
LEWES, DELAWARE 19958
Phone: 302-644-3311 Fax: 302-644-3300

AUTHORIZATION TO RELEASE PROTECTED HEALTH INFORMATION TO THE PERSON OR ENTITY LISTED BELOW FOR USE AND DISCLOSURE

Patient Name: _____ DOB: _____

I hereby authorize Orthopaedic Associate of Southern Delaware, P.A. (OASD) to release my individually identifiable Protected Health Information (PHI) to **(List full name of requesting person & place of business):** _____ _____To use and disclose for the specific purpose of **(List what the requesting person and/or entity wants to use the PHI for):** _____

I understand that my PHI may be redisclosed by the person or entity receiving my PHI from OASD, and that it then may no longer be protected by federal privacy regulations. State law may or may not prohibit such redisclosure by the person or entity receiving my PHI from OASD. I voluntarily sign this authorization and I understand that my health care will not be affected if I do not sign this form.

THE FOLLOWING PHI IS TO BE RELEASED: (PATIENT OR PATIENT REPRESENTATIVE MUST CHECK ONE BOX FOR EACH ITEM):

Yes	No	Items Requested	Yes	No	Items Requested
☐	☐	Physician Notes	☐	☐	Drug/Alcohol Abuse
☐	☐	Lab Results	☐	☐	HIV Test Results
☐	☐	X-ray Reports	☐	☐	Mental Health Records
☐	☐	MRI Scans	☐	☐	OASD Claims/Billing Information
☐	☐	CT Scans	☐	☐	Complete Record generated by OASD to include Claims/Billing Information
☐	☐	EMG Reports			
☐	☐	Bone Scans	☐	☐	Complete Record generated by OASD do not include Claims/Billing Information
			☐	☐	Other: _____

_____

This authorization will expire on [date no more than one year in advance): _____

I understand that I have the right to receive a copy of this authorization. I also understand that I may revoke or modify this authorization at any time by notifying OASD in writing. I understand that my revocation or modification of this authorization will not affect any actions taken by OASD in reliance on this authorization before OASD receives my request for revocation or modification. I must sign and date my written request and send it to the following address:

Medical Records Department
Orthopaedic Associates of Southern Delaware, P.A.
17005 Old Orchard Road
Lewes, Delaware 19958

Signature of Patient or Patient Representative: _____ Date: _____

If you are signing as the patient's representative, print your name: _____

Please indicate your relationship to the patient:
☐ Parent, guardian or caregiver of a minor patient
☐ Guardian or conservator of an incompetent patient.
☐ Beneficiary or personal representative of a deceased patient.
☐ Other: _____ (Specify Relationship)