Orthopaedic Surgery and Sports Medicine of Dallas, PLLC
www.OSSMDallas.com
Phone 214.265.5050

AUTHORIZATION TO RELEASE PROTECTED HEALTH INFORMATION

(Please Print or Type)

Patient Name:_____ Social Security Number:_____

Address:_____ Date of Birth:_____

City, State, Zip:_____ Phone Number:_____

I hereby authorize Orthopaedic Surgery and Sports Medicine of Dallas, PLLC, to release information from my medical record by

☐ Mail ☐ Fax ☐ Email to:

Name_____

Address_____

City, State, Zip_____

Tel Number_____ Fax Number_____ Email Address_____

Purpose of this Release:_____

My authorization is confined to the following specific information initialed below:

_____Statements for charges or payments

_____Progress notes

_____Discharge summary

_____Consultation reports

_____Records or reports of visits for specific date(s) of:_____

_____Photographs, digital, or other images

_____History and physical examination

_____All of the above

_____Other (Must be specific)_____

_____Mental health and/or alcohol and drug abuse treatment

_____AIDS (Acquired Immunodeficiency Syndrome) or HIV (Human Immunodeficiency Virus) information

_____Hepatitis information

_____Records or reports for visits (all visits)

This authorization is given freely with the understanding that:

1. Any and all records, whether written or oral or in electronic format, are confidential and cannot be disclosed without my prior written authorization, except as otherwise provided by law.
2. A photocopy or fax of this authorization is as valid as this original.
3. I may revoke this authorization at any time, except where information has already been released. This authorization is valid for a one year period from the date it is signed, or sooner if noted below. The revocation must be in writing. A revocation form is available upon request.
4. Orthopaedic Surgery and Sports Medicine of Dallas, LLC, its employees, officers, and physicians are hereby released from any legal responsibility or liability for disclosure for the above information to the extent indicated and authorization herein.
5. Treatment, payment, enrollment, or eligibility for benefits may not be conditioned upon this authorization.
6. Information used or disclosed pursuant to this authorization may be subject to re-disclosure by the recipient and is no longer protected.

_____ _____

PATIENT OR PERSONAL REPRESENTATIVE'S NAME PRINTED

DATE, EVENT, OR CONDITION OF EXPIRATION (IF OTHER THAN ONE YEAR FROM DATE SHOWN ABOVE)

_____ _____

PATIENT OR PERSONAL REPRESENTATIVE'S SIGNATURE

DATE

_____ _____

WITNESS

DATE