ADVANCED ORTHOPAEDIC ASSOCIATES, P.A.

9828 E. Shannon Woods. Ste 100, Wichita, KS 67226
(316) 631-1600 Fax (316) 631-1617
medicalrecords@aoaortho.com
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PATIENT AUTHORIZATION TO USE OR DISCLOSE PROTECTED HEALTH INFORMATION (PHI)

PATIENT NAME: _____ DATE OF BIRTH: _____
PATIENT'S ADDRESS: _____

I HEREBY AUTHORIZE ADVANCED ORTHOPAEDIC ASSOCIATES, P.A. TO DISCLOSE PHI TO:

_____
Name of Recipient

Select delivery method:

☐ *Email* ☐ *Mail*

_____ _____
Email Address of Recipient *Mailing Address of Recipient*

I HEREBY AUTHORIZE ADVANCED ORTHOPAEDIC ASSOCIATES, P.A. TO RECEIVE PHI FROM _____
Name of person(s)/organization(s)

Treatment Dates Covered by this Authorization:_____
Specific Dates or Date Range

Type of Information Authorized to be Used and /or Disclosed. Check All Boxes that Apply:

If this authorization applies to the complete office medical records, check here ☐. *Otherwise, specify your request by checking appropriate boxes* in the three columns below.

Specify Data Requested

- ☐ Office Notes
- ☐ Surgery Reports
- ☐ Therapy Reports
- ☐ Billing Records
- ☐ X-ray Films
- ☐ X-ray Reports

Specify Treating Physician

- ☐ Dr. Adrian
- ☐ Dr. Anderson
- ☐ Dr. Bollinger
- ☐ Dr. Childs
- ☐ Dr. Corrigan
- ☐ Dr. Dart
- ☐ Dr. Fanning
- ☐ Dr. Gwyn
- ☐ Dr. Hagan
- ☐ Dr. Hendricks
- ☐ Dr. Jansson
- ☐ Dr. Lais
- ☐ Dr. Lucas
- ☐ Dr. Morris
- ☐ Dr. Pappademos
- ☐ Dr. Prohaska
- ☐ Dr. Scott
- ☐ Dr. Shepherd
- ☐ Other

Specify Encounter / Problem

- ☐ Shoulder
- ☐ Elbow / Arm
- ☐ Wrist / Hand
- ☐ Back / Spine
- ☐ Hip / Leg
- ☐ Knee
- ☐ Ankle / Foot

Effective Date:

This authorization shall remain in effect until _____*(date)* or_____(*specific occurrence or event*) at which time the authorization shall expire. Date or occurrence must be no later than one year from the date of authorization. If this item is left blank, this authorization shall remain effective for 60 days.

*"All records" means all protected health information in a designated record set, which includes but is not limited to patient family histories, genetic information, inpatient/outpatient records, medical, dental, psychiatric, alcohol/chemical/substance abuse, HIV/AIDS, pharmaceutical, hospital or physician records, office notes, narrative summaries, telephone messages, correspondence to/from/ about me, diagnostic testing results, bills, statements & invoices (this includes all records including records from other health care providers).

- This request for disclosure of medical records/information is made at my request for (state reason for the disclosure:_____ .
- I understand that if the person or entity that receives the described records/information is not a health care provider or health plan covered by federal privacy regulations, the records/information may be re-disclosed and no longer protected by those regulations.
- I understand that certain records may be protected by federal or state law and I am requesting that any and all such protected records be released under this authorization.
- I understand that I may revoke this authorization at any time by delivering/mailing a *written* revocation to the party or attorney or law firm named in Block 2 above.
- If I revoke this authorization it will have *no* effect on actions already taken on reliance on this form.
- I also understand that the covered entity will not condition treatment, payment, enrollment or eligibility for benefits on whether I sign the authorization. I also understand that I may have a copy of this form after I sign it.
- I understand it is no longer AOA's responsibility once the medical records have left this office.
- I understand that fees may be charged for preparing and sending copies of records, including a charge for labor and supplies of $18.95 per request, and $.60 per page up to 250 pages, then $.45 for each additional page.
- I authorize the disclosure of the records/information described. I have read and understand this form. I am the patient listed or am authorized to act on behalf of the patient as the patient's personal representative. I also permit disclosure of the records upon presentation of a photocopy of this authorization.

_____ _____

Signature of Patient or Patient Representative Date

_____ _____

Patient or Representative Mailing Address and Telephone Number Printed Name of Patient or Representative and Relationship to Patient

_____ _____

Signature of Witness Date

***This authorization should not be utilized for uses or disclosures related to the sale of protected health information, marketing or research.**

Original to be maintained in patient's permanent medical record.

Revised 3/24/2023

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Revocation of Authorization:

I, _____(*name*), HEREBY REVOKE THE AUTHORIZATION TO USE OR DISCLOSE HEALTH CARE INFORMATION DESCRIBED ON THE RELEASE SIGNED AND DATED BY ME ON _____.

_____ _____

Signature of Patient/Patient Representative Date

_____ _____

Patient Representative Mailing Address and Telephone Number Printed Name of Patient Representative and Relationship to Patient

_____ _____

Signature of Witness Date