

ORTHOPEDIC PROFESSIONAL ASSOCIATION, P.C.

X RAY RELEASE

PATIENT: _____ DATE OF BIRTH _____
Please print

This is to acknowledge that I have:

_____ A. Received my x rays

_____ B. Given permission for my x rays to be released to my representative named below.

It is my understanding that I am responsible for returning these x rays to OPA.

Patient Signature: _____ Date _____

Patient Representative Signature: _____

Printed Name of Patient Representative _____

ORTHOPEDIC PROFESSIONAL ASSOCIATION, P.C.

AUTHORIZATION TO USE OR DISCLOSE MY PROTECTED HEALTH INFORMATION (PHI)

Patient Name: _____ Date of Birth: _____

You may use or disclose the following health care information:

____ All my health information maintained by the above practice

OR

(Circle **include** or **exclude** for each of the following)

include or exclude: My health information related to drug abuse

include or exclude: My health information related to alcohol abuse

include or exclude: My health information related to HIV/AIDS

include or exclude: My health information related to psychological !or
psychiatric conditions

include or exclude: Other _____

You may disclose this health information to:

Name (or title) and organization: _____

Address _____ City _____ State _____ Zip _____

Reason (s) for this authorization:

____ at my request

____ Other: _____

This authorization ends:

____ No end - always in effect

____ On (date) _____

____ When the following event occurs _____

I may revoke this authorization in writing. If I do, it will not affect any actions already taken by the above named practice. I may not be able to revoke this authorization if its purpose was to obtain insurance.

Once the office discloses health information, the person or organization that receives it may re-disclose it. Privacy laws may no longer protect it: Records previously obtained from other providers could contain information that may be sensitive to you, and we cannot-vouch for their completeness.

Patient or legally authorized individual signature

Date

Printed name if signed on behalf of the Patient

Relationship to Patient