

## HIPAA AUTHORIZATIONFOR USE OR DISCLOSURE OF HEALTH INFROMATION

## Patient Directed Request Only Only for COC Requests

	<del></del>
Patient Information:	
Name:	December December
Date of Birth:	Reason for Request:
Address:	□ Continuity of Care
City: State: Zip:	
Cell Phone-Required:	
Records to be Provided from: (Enter Your Doctors/Office	Send Records To:
information)	
Facility/Provider: Barrington Orthopedic Specialist	DR
Address: 929 West Higgins Road	City: State: Zip:
City: Schaumburg State: IL Zip: 60195	Phone:
Phone: 847-285-4200	Fax-Required:
Fax: 847-885-0130	- an required -
14X 017 003 0130	
Information to be Disclosed:  Dates of Service requested: To	
□ Complete Record	
. □ Office Notes □ Laboratory Report(s) □ Physical Therapy □ Imag	es CD (Xrav. MRI)
□ Imaging/Radiology Reports □ Test Result (s) of:	• •
□ Other:	nclude information relating to sexually transmitted diseases, acquired or
	authorize the release of all such items <u>EXCEPT</u> for those which I have marked
below. By checking the boxes next to these items, I understand that th	
□ Alcohol or Substance Abuse Records □ HIV and/or STD Testing	
By signing this authorization form, I understand that:	
by signing this authorization form, i understand that.	
• I understand that communications via email over the internet are not secu	are. Although it is unlikely, there is a possibility that information included in an email
	m it is addressed. The provider has notified me of the risks and will not be held liable
if I choose to have my records sent by email.	and the first of a second consisted as a first the books before
I have the right to revoke this authorization at any me. Revocation must b     Management Department at the facility at which this request is received. Re	e made in wring and presented or mailed to the health informa on evocation will not apply to information that has already been disclosed in response to
this authorization.	
•I have a right to inspect and copy the health information disclosed as a resu	
	ate/event/condition: If I fail to specify an
expiration date/event/condition, this authorization will expire one year from •Treatment, payment, enrollment, or eligibility for benefits may not be cond	
	and the information may no longer be protected by federal confidentiality rules.
• If any, Consequences of Failure to consent:	<u> </u>
Patient or Authorized Representative Signature	Date Relationship to Patient (if applicable)