The Ryu Hurvitz Orthopedic Clinic

AUTHORIZATION FOR USE AND DISCLOSURE OF MEDICAL INFORMATION

This authorization allows the healthcare provider(s) named below to release confidential medical information and records. Note: *Information and records regarding treatment of minors, HIV, psychiatric/mental health conditions, or alcohol/substance abuse have special rules that require specific authorization.*

AUTHORIZATION

I hereby authorize: ____

(Indicate: Dr. Ryu, Dr. Hurvitz, Dr. Yau or Dr. Thomas)

To release information regarding my medical history, illness or injury, consultation, prescriptions, treatment, diagnosis or prognosis, including x-rays, correspondence and/or medical records by means of mail, fax or other electronic methods.

Release to: ______________________________ ____________________

Name Phone or Fax Number

____

Address

______________________________ __________ __________

City State Zip Code

The medical records to be included are:

[ ] Unlimited (all records, excluding Substance Abuse, Mental Health, HIV Diagnosis/Treatment)

[ ] Limited to the following medical information: ______________________________

[ ] Include **paper** copy of x-ray images (only applicable to those taken in-office) – no charge

[ ] Include a **CD** of x-ray images (only applicable to those taken in-office) - **$15 charge due upon pick-up**

I also consent to the specific release to the following records:

Drug/Alcohol/Substance Abuse ______ (Initial) Tests for Antibiotics to HIV ______ (Initial)

Psychiatric/Mental Health ______ (Initial) HIV Diagnosis/Treatment ______ (Initial)

DURATION This authorization shall be effective immediately and remain in effect until ____________________

Date

RESTRICTIONS

Permissions for further use or disclosure of this medical information is not granted unless another authorization is obtained from me or unless such disclosure is specifically required or permitted by law.
A photocopy or facsimile of this authorization shall be considered as effective and valid as the original.
I have been advised of my right to receive a copy of this authorization.

______________________________ ____________________

Signature of Patient or *Legal Personal Representative* Relationship *if other than patient*

______________________________ ____________________

Patient's Name (PRINT) Date

____

Patient's Date of Birth