Orthopaedic Specialists of Austin

4611 Guadalupe St. Suite 200
Tel: 512-476-2830 Fax: 512-476-2832

Medical Record Release Authorization

ORTHOPAEDIC SPECIALISTS OF AUSTIN

Patient Name _____

Date of Birth _____ Phone# _____

Address _____ City/State/Zip _____

Email Address _____

A) I hereby authorize records FROM:

Name Orthopaedic Specialists of Austin

Address 4611 Guadalupe St STE200

City/State/Zip AUSTIN, TX. 78751

Phone# 512/476-2830 Fax# 512/476-2832

B) To be released TO:

Name _____

Address _____

City/State/Zip _____

Phone# _____ Fax# _____

Date Range _____ to _____

- ☐ Physician Office Notes
- ☐ Imaging (CD & Reports) $8.00
- ☐ Imaging (Report ONLY)
- ☐ Other _____
- ☐ Operative Reports
- ☐ Lab/Path Reports
- ☐ Procedure Reports
- ☐ Billing Records

ALL DATES will be provided if no range specified. I understand that authorizing the disclosure of this health information is voluntary. I can refuse to sign this authorization. I need not sign this form in order to assure treatment. I understand that any disclosure of information carries with it the potential for an unauthorized re-disclosure and the information may not be protected by federal confidentiality rules. If I have questions about disclosure of my health information, I can contact the authorized individual or organization making disclosure.

I understand that the information in my medical record may include information relating to sexually transmitted disease, acquired immunodeficiency syndrome (AIDS), or human immunodeficiency virus (HIV). It may also include information about behavioral or mental health services, and treatment for alcohol and drug abuse.

I understand that I have a right to revoke this authorization at any time. I understand that if I revoke this authorization, I must do so in writing and present my written revocation to the Medical Records Department. I understand that the revocation will not apply to information that has already been released in response to this authorization. I understand that the revocation will not apply to my insurance company when the law provides my insurer with the right to contest a claim under my policy.

I have read the information provided on this release form and do hereby acknowledge that I am familiar with and fully understand the terms and conditions of this authorization. Authorization may be retracted in writing unless I specify an expiration date: _____
(Expiration date of authorization)

_____ _____
(Date) (Signature of Patient/Parent/Guardian or Authorized Representative)