HAHN ORTHOPEDICS and SPORTS MEDICINE

DR. JOSEPH HAHN

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AUTHORIZATION FOR RELEASE OF PROTECTED HEALTH INFORMATION

I authorize the release of my Protected Health Information (PHI) from:

____

and mail or fax Hahn Orthopedics, 10 Valley View St. Suite 101, Petersburg, WV 26847. Fax: 304-257-9790.

The medical records to be released may contain medical information pertaining to psychiatric, drug, and/or other alcohol diagnosis and treatment. The purpose or need for such disclosure is:

____

Authorization to release the following medical reports: Please check all desired information to be sent.

___ ALL HEALTH INFORMATION

OR *ONLY* RELEASE INDICATED RECORDS:

___ History Form ___ Doctor Notes ___ Laboratory Reports

___ Operative Reports ___ Radiology Reports ___ Therapy Notes

___ EKG, EEG and/or EMG Report ___ Progress Notes

___ Radiology Images ___ Emergency Room Records

___ Other information or instructions ____

THE FOLLOWING INFORMATION REQUIRES SPECIAL CONSENT BY LAW.
Even if you indicate *all health information*, you must specifically request the following information in order for it to be released and it cannot be combined with any other request.

___Chemical Dependency Programs ___Psychotherapy Notes

This authorization shall expire, without my express revocation, 120 days from the date written below. I understand that I have the right to withdraw this authorization at any time, except to the extent that action has been taken based on this authorization. I understand this information is no longer protected from disclosure.

Patient Signature: ______________________ Patient Name: ________________________

Patient Phone Number: __________________ Patient SS#: __________________________

Witness: ______________________________ Date: ______________________________