ORCA
ORTHOPAEDIC RESEARCH CLINIC ALASKA

AUTHORIZATION TO RELEASE/OBTAIN MEDICAL RECORDS

Orthopedic Research Clinic of Alaska
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Visit us online at ORCAAK.com

I authorize Doug A. Vermillion, MD, to _____release / _____obtain a copy of the medical information for:

_____ _____ _____
PATIENT NAME DATE OF BIRTH TODAY'S DATE

This information may be _____released to / _____obtained from:

_____ (Name of physician/clinic) _____ (Phone)

_____ (Address) _____ (Fax)

Information requested for the following purpose:
_____ patient treatment _____ payment/billing _____healthcare operations

By checking or initialing the spaces below I specifically authorize the use or disclosure of the following health information and/or records, as such information and/or records exist:

_____ Entire medical record (all information, including X-Ray images)
OR
_____ Medical records needed for continuation of care _____ Laboratory and/or Pathology reports
_____ Office chart notes _____ Hospital surgery reports by Dr. Vermillion
_____ Diagnostic imaging/x-ray reports _____ X-Ray images _____ Billing statement/full account ledger
_____ Other: _____

I understand that the information in my health 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/or drug abuse. I also understand it will not be released without my specific authorization. As outlined in Orthopaedic Research Clinic of Alaska's Notice of Privacy Practices, I understand I have the right to revoke this authorization at any time. I understand that if I revoke this authorization, I must do so in writing and send it to ORCA. I understand that this will not apply to information that has already been released as a result of 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. ***Unless otherwise revoked or specified below, this authorization will expire 6 months from the date it was completed.*** _____ (Patient initials/ date)

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 I may inspect or copy the information to be used or disclosed, as provided in 45 CFR 184.524. ***I understand that any disclosure of information carries with it the potential for an unauthorized re-disclosure and may no longer be protected by federal confidentiality rules.*** If I have questions about disclosure of my health information I can contact ORCA. I understand that the first copy of my record and subsequent updates will be free of charge when they are requested by and given to me. If any additional copies of the entire chart are requested a fee for labor, cost of supplies and postage will be charged; the final cost will depend on the size of the chart. _____ (Patient initials/date)

PLEASE NOTE: These are your copies. If you take them to another physician, a lawyer, etc., it is advisable that you make a copy for yourself first.

_____ _____
Signature of Patient/Legal Representative Expiration Date of Authorization

_____ _____
Relationship if other than patient Authority to Act as Patient Representative
(Legal guardian, Power of Attorney, etc.)

FOR OFFICE USE ONLY

Date Completed _____ Completed by _____