Baton Rouge Orthopaedic Clinic

Authorization for Release of Medical Records
Must be Completed

I hereby authorize Baton Rouge Orthopaedic Clinic to use or disclose the following protected health information (PHI) from the medical records of the patient listed below to:

Requested By: _____
Address: _____
_____

Patient Name: _____
Patient DOB: _____
Patient SSN: _____
Patient Address: _____
_____

Disclose the following PHI for treatment dates _____ to _____.

___History & Physical ___Progress Notes ___Consult
___Physician Orders ___X-Ray Report ___Nurses Notes
___Chart Notes ___Other Specify ___MRI Results*
*If Applicable

The above information is disclosed for the following purpose(s):

___Another physician ___Legal ___Insurance ___Personal ___Other

_____I acknowledge, and hereby consent to such, that the released information may contain alcohol and drug abuse, psychiatric, HIV or genetic information.

This authorization shall expire upon this expiration date: _____
***If a specified date is not entered the authorization will expire in six (6) months from the date form is signed.

- I understand that I have the right to revoke this authorization at any time and must do so in writing to BROC. I understand that this revocation will not apply to information that has already been released pursuant to the authorization.
- The information used or disclosed pursuant to the authorization may be subject to redisclosure by the recipient and no longer protected.
- My treatment, payment, enrollment or eligibility for benefits may not be conditioned on signing this authorization.

I have read the above and authorize the disclosure of the protected health information as stated.

_____ _____
Signature of Patient/Legal Guardian Date

_____ _____
Witness Date