Orthopaedic Specialty Group, P.C. & Fairfield Surgery Center, LLC

305 Black Rock Turnpike, Fairfield, CT 06825

Authorization for Obtaining, Use or Disclosure of

Protected Health Information

As required by the Health Insurance Portability and Accountability Act of 1996 (HIPAA) and Connecticut law, this practice may not use or disclose your individually identifiable health information without your authorization except as provided in our Notice of Privacy Practices. Your completion of this form means that you are giving permission to use, disclose, inspect or obtain your medical information. Please review and complete this form carefully. It may be invalid if not fully completed.

I hereby authorize this Orthopaedic Specialty Group, P.C. to use and disclose health information concerning:

Patient Name	Last 4 OF Social Security Number	Date of Birth / /	Patient ID
Street Address City, State Zip			Telephone number

Person or organization authorized to provide the health information: ☐OSG ☐Other

Individual/ Organization Name	Telephone Number
Street Address City, State Zip	Fax Number

Person or organization authorized to receive the health information:

☐ OSG ☐ Self/ Designee ☐ Disability/FMLA ☐Transition of Care ☐ Attorney ☐ Other

Individual/ Organization Name	Telephone Number
Street Address City, State, Zip	Fax Number

SCOPE OF ACCESS REQUESTED

I would like copies of:

☐ All the records or
☐ The portion of the records concerning
☐ X-Ray CD (not compatible with Apple/Mac devices)
☐ MRI CD (not compatible with Apple/Mac devices)

(Specify type of disease, body part, accident, dates of treatment, or other portion of records you are interested in. If requesting copies of X-Rays; specify report or films)

Restricted Access

All information regarding Alcohol and/or Drug Abuse or Behavioral Health will be released **unless you restrict by initialing** below:

_____Alcohol/Drug _____HIV/AIDS _____Mental Heath

Imaging CD and Copies Fees and Time Frames

I understand I may be charged a reasonable fee of up to $.65 per page, including any research fees, handling fees and the cost of first class postage, if applicable, for copies of the information requested. I also understand that I will be charged a fee to cover the cost of materials for providing a copy of an x-ray: $6.00 for CDs picked up and $10.00 for CDs mailed. Please provide 7 working days to process.

I have read and understand the following statements about my rights:

- I am not required to sign this form in order to receive healthcare services.
- I may revoke this authorization at any time prior to its expiration date by notifying the medical practice in writing. This revocation will not have any effect on any actions taken before the medical practice received the revocation.
- I may receive a copy of this authorization form.
- Once this information is disclosed pursuant to this Authorization, it is no longer protected by this medical practice's privacy policies, and may possibly be re-disclosed by the recipient.

This authorization is effective for one year from date of signature unless otherwise stipulated below:

Date: _____ End of event: _____

Signed: _____ Dated: _____

Print Name: _____

If not signed by the patient, please indicate relationship: _____

Forward request to: Privacy Official
OSG
305 Black Rock Turnpike
Fairfield, CT 06825
Fax: 203-337-2622

For office use only
- ☐ Records will be picked up
- ☐ Please fax records
- ☐ Please mail records
- ☐ Copy fee $ _____
- ☐ Records picked up on _____
- ☐ Payment received on _____
- ☐ Records sent on _____
- ☐ Enter Care Alert