NEWPORT
ORTHOPEDIC INSTITUTE

Medical Records Release

Note: This form is used for when a patient is requesting that NOI disclose their medical record to another healthcare provider.

I hereby authorize Newport Orthopedic Institute ("Provider") to disclose to all of the information contained in my Medical Record(s). I understand that after the custodian of records discloses my health information, it may no longer be protected by federal privacy laws. I further understand that this authorization is voluntary and that I may refuse to sign this authorization. My refusal to sign will not affect my ability to obtain treatment; receive payment; or eligibility for benefits unless allowed by law. By signing below I represent and warrant that I have authority to sign this document and authorize the use or disclosure of Protected Health Information (PHI) and that there are no claims or orders pending or in effect that would prohibit, limit, or otherwise restrict my ability to authorize the use or disclosure of this Protected Health Information.

The specific Protected Health Information that will be used or disclosed is:

Patient Name: _____

Patient ID: _____

Date of Birth: _____

Date(s) Records Request From: _____ To: _____

Address: _____

City, State, ZIP: _____

Telephone Number: _____

Specially-Protected Information

Special laws may restrict the use and disclosure of medical information related to mental health conditions, substance abuse, sexually transmitted diseases and HIV/AIDS. For example, we generally do not disclose specially protected information in response to a subpoena or other compulsory process unless: 1) you provide written authorization; or 2) a court orders the disclosure and mandates the necessary safeguards to protect the information after it is released. I understand that the Provider will produce this information within 15 business days from receipt of request, and I may be subject to a reasonable clerical cost for preparing and furnishing this information. California Evidence Code Section 1560-1567, Evidence Code Section 1158, Health & Safety Code Section 123100.

The Person(s) to whom we will disclose the information, and who my use it, are:

Name: _____

Address: _____

City, State, ZIP:_____

Phone: _____ Fax: _____

Patient/Representative Signature: _____ Date: _____

Representative Printed Name: _____

Relationship to Patient: _____