Blue Ridge Orthopaedic & Spine Center

AUTHORIZATION TO USE OR DISCLOSE PROTECTED HEALTH INFORMATION

Patient Name: _____ Acct# and/or DOB: _____

I authorize Blue Ridge Orthopaedic & Spine Center and/or their administrative and clinical staff to use or disclose the following protected health information: Please initial the appropriate section of your protected health information that you are requesting.

____ Entire Medical Record ____ Lab and/or X-ray Results ____Most Recent Office Note
____Demographic Information ____Other (please specify) _____

____X-rays: ____Cervical Spine ____thoracic spine ____lumbar spine ___pelvis
____shoulder ____humerus ____forearm ____wrist ____hand ____hip ____femur ___knee
____tibia/fibula ____ankle____ foot _____other

Record Request Fees: In accordance with Virginia legislation there may be a charge for electronic/paper copies of medical records in which payment will be required in full.

This authorization permits Blue Ridge Orthopaedic & Spine Center to ***send*** the specified protected health information to the following address or fax:

_____ _____
_____ _____
_____ _____

I understand that information used or disclosed pursuant to this authorization may be disclosed by the recipient and may no longer be protected by federal or state law. I understand that I have the right to revoke this authorization, in writing, at any time by sending such written notification to the practice's Privacy officer at 52 West Shirley Avenue, Warrenton VA 20186. Revocations are not effective until received by the Privacy Officer. The revocation must include the patient's account number, name, address, the date of the original authorization, the recipients of the original authorization, the date of the revocation and the patient's signature. Blue Ridge Orthopaedic & Spine Center will accept written revocations of this authorization via: U.S. mail, in person, or by fax (540) 347-0492.
This authorization shall expire two years from the date of signature.

_____
Signature of Patient or Personal Representative

_____
Date

_____
Name of Personal Representative's Authority

_____
Description of Personal Representative's Authority

For Office Use Only: _____Mailed _____Faxed on: _____

Picked up by: Patient _____; Other, Name: _____

Employee Signature: _____