ROTHMAN ORTHOPAEDICS

Release of Information Request

By my signature below, I knowingly and voluntarily authorize the Rothman Institute and its employee and agents to us and/or disclose protected health information (PHI) about me in the manner described in this authorization for the purpose of:

□ My personal request

□ The completion of my disability forms (date disability began _____/expected return to work date _____)

□ Other

_____

I am requesting □ Medical Record □ Imaging Studies taken on _____ □ Disability Form Completion

In the event that requested information to be released contains mental health records, genetic information, venereal disease-related records, tuberculosis-related records, drug and alcohol treatment records and/or HIVAIDS-related diagnosis treatment information, I specifically

□ authorize release of such information □ do not authorize release of such information

I do not have to sign this authorization in order to receive treatment from the Rothman Institute. In fact, I have the right to refuse to sign this authorization. When my information is used or disclosed pursuant to this authorization, it may be subject to re-disclosure by the recipient and may no longer be protected by the Federal HIPAA Privacy Rule. I have the right to revoke this authorization in writing except to the extent that the Practice has acted in reliance upon this authorization. My written revocation must be submitted to the Rothman Institute, 833 Chestnut St, Suite 500, Philadelphia, PA 19107. I have read this authorization and understand its terms. I have had an opportunity to ask questions about the use and/or disclosure of my Personal Health Information. **Fax to: 267-551-2990**

«FirstName» «LastName»
Patient Name (Print: First, Middle, Last)

***
Patient Signature

Personal Representative Name (Print first, MI, Last)

Personal Representative Signature

Representative's Relationship to Patient

Date:

Patient Information			
Patient Name	«LastName» (First) «FirstName»		
Patient Street Address	«MailingAddress1»	Date of Birth	«DOB»
City, State, Zip	«MailingAddress2»	Phone	«HomePhone»

I am requesting □ Medical Records □ Imaging Studies taken on _____ □ Disability Form Completion

Recipient Information	
Company Attention of Name (Last) (First) (MI)	
Street Address	Phone
City	Fax
State Zip	E-mail

ROTHMAN ORTHOPAEDICS

Patient Name: «FirstName» «LastName»
Account #: «PatientAcccountNumer»
DOB: «DOB»

Payment and Processing Information
There is a fee associated with requests for medical records, x-rays, duplicate MRI's and disability form completion. Medical Record Requests: All requests for copies of medical records will be mailed to the person or company listed as the recipient of the information. All fees associated with requests for copies of medical records will be invoiced to the requestor and are required to be paid prior to the request being processed. Theses fees will include any applicable state tax and shipping fees associated with mailing the requested records. Please allow 7-10 business days to process your request after payment has been received. Request for Copies of X-rays: X-ray copies are provided digitally and cost $5. Individuals requesting their copies to be mailed are subject to shipping fees. Please allow 7-10 business days to process your request. Request for Duplicate Copies of MRI: A courtesy copy of any MRI studies performed will be provided to patients free of charge. Duplicate or additional copies of any MRI studies will be provided at a cost of $50 per study. Individuals requesting that theses copies be mailed will be subject to shipping fees in addition to the cost for duplicate copies. Please allow 7-10 business days to process your request. Disability Form Completion: Disability, FMLA and other forms will be completed at a cost of $20 per form. Please allow 7-10 business days for form completion.

OFFICE USE ONLY	Fee	Check	Cash	Credit Card
Duplicate MRI	$ 50.00 per Study + Shipping			
X-ray CD	$ 5.00 + Shipping			
Disability Forms	$ 20.00 per form			
	*For disability forms, please note name of treating provider: Dr.			
Medical Record	*Will be Billed to Requestor*	*N/A*		

Staff Member Name _____ *Signature* _____ «encDate» *Date*