WHITE RIVER ORTHOPAEDIC
SPORTS AND HAND SURGERY CLINIC

MR # _____

2110 E. Main St. ● Mountain View, AR, 72560

Authorization of Release of Medical Records

1. Patient Name: _____ Date of Birth: _____

   Patient Address: _____ City:_____ State:_____Zip: _____

   Verified Photo ID ☐
2. Dates of Service of requested records: _____
3. Person or Organization to whom the medical records information should be disclosed:

   _____

   _____
4. I understand that the information in my medical record may include information relating to sexually transmitted disease, acquired immunodeficiency (AIDS), or human immunodeficiency virus (HIV). It may also include information about behavioral or mental health services.
5. The information for which I am authorizing disclosure will be used for the following purposes:
   - ☐ Personal Use
   - ☐ Legal purposes
   - ☐ Continued Care
   - ☐ Insurance purposes
   - ☐ Other
   - ☐ At the request of individual
6. I would like my records provided to me or the designated third party/other via:
   - ☐ US Mail – paper format
   - ☐ Email – secure format
   - ☐ Email – unsecure format
   - ☐ Fax – healthcare provider only
   - ☐ CD – secure format
   - ☐ CD – unsecure format
   - ☐ Other

**By selecting unsecure email, I understand that any information sent via unencrypted email is not a secure method of transmission and cannot be protected by the provider. I also understand that my patient information could be intercepted and redistributed without my knowledge or permission.*

7. The type of information to be disclosed is as follows (check the appropriate box)
   - ☐ History and Physical and Discharge Summary
   - ☐ Operative/Procedure Reports
   - ☐ Physicians Progress Notes/Orders
   - ☐ Emergency Department Reports
   - ☐ Lab and x-ray Reports
   - ☐ Entire Medical Record for period stated above
   - ☐ Billing Records
8. I understand that I have the right to revoke this authorization at any time. I understand that if I revoke this authorization, I must do so in writing and present the written revocation to the Health Information Management Department. I understand that the revocation will not apply to information that has already been released in response to this authorization. I understand that the revocation will not apply to my insurance company when the law provides my insurer with the right to contest a claim under my policy.
9. This authorization will expire in one year from the date on which it was signed unless otherwise specified by the patient.
10. I understand that once the above information is disclosed, it may be re-disclosed by the recipient and the information may not be protected by the federal privacy laws or regulations.
11. I understand authorizing the disclosure of the information identified above is voluntary. I need not sign this form to ensure healthcare treatment.

_____ _____

Signature of Patient or Authorized Representative | Relationship to Patient

_____ _____

Printed Name | Date