

AUTHORIZATION FOR RELEASE OF MEDICAL RECORDS

PATIENT IDENTIFICATION	Patient Name _____	Date of Birth _____
	Address _____	
	City, State, Zip _____	
	Telephone No. _____	Social Security No. _____

I request and authorize Orthopaedic Associates of Central Texas/Austin Bone & Joint Clinic to release medical information of the patient named above.

RELEASE RECORDS TO: (where records should be sent)	<input type="checkbox"/> Fax <input type="checkbox"/> Mail <input type="checkbox"/> Pick up in person
<i>Same address as above</i>	
Name/Agency _____	
Address, City, State, Zip _____	
Phone Number _____	Fax Number _____

RELEASE RECORDS FROM:	
Name/Agency _____	
Address, City, State, Zip _____	
Phone Number _____	Fax Number _____

MEDICAL RECORDS TO INCLUDE	Dates of Treatment to be Released: _____ to _____	
	<input type="checkbox"/> History and Physical Exam	<input type="checkbox"/> X-Ray Copies** <input type="checkbox"/> All Records
	<input type="checkbox"/> Consultations	<input type="checkbox"/> MRI Copy**
	<input type="checkbox"/> Medications	<input type="checkbox"/> Other (specify) _____
	<input type="checkbox"/> Progress Notes	** All imaging on CD only, \$10 fee to be paid at time of record request

PURPOSE OF RELEASE	<input type="checkbox"/> Patient Care	<input type="checkbox"/> Appointment sharing with other healthcare provider
	<input type="checkbox"/> Personal Use	<input type="checkbox"/> Disability/Insurance Application/Claim
	<input type="checkbox"/> Administrative (i.e. FMLA)	<input type="checkbox"/> Attorney/Legal Case
	<input type="checkbox"/> Military	<input type="checkbox"/> Other (specify) _____

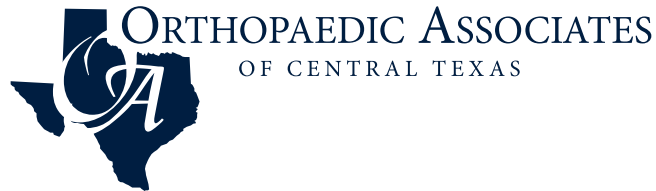
1. I understand that the information in my health record may include information relating to sexually transmitted disease, acquired immunodeficiency syndrome (AIDS), or human immunodeficiency virus (HIV). It may also include information about behavioral or mental health services, and treatment for alcohol and drug abuse.
2. I understand that I have a right to revoke this authorization at any time. I understand that if I revoke this authorization I must do so in writing and present my written revocation to the medical records department. I understand that revocation will not apply to my insurance company when the law provides my insurer with the right to contest a claim under my policy.
3. Medical Practice Act 159.006 - Upon receipt of a proper written request, **the office has 15 business days to release a copy of the medical records.** TSBME Rules 165.2(b)- The requested copies of records shall be furnished by the office within 15 business days after the date of the receipt of the request.
4. I understand that my medical records may contain copies of information received from other healthcare facilities and due to Federal Regulations those records must be released from the original medical facility and not from Orthopaedic Associates of Central Texas.

Signature of Patient or Legal Representative

Date

Relationship to Patient

Witness



North Austin - OACT

12309 N. Mopac Expy.
Suite 150
Austin, TX 78758

Cedar Park - OACT

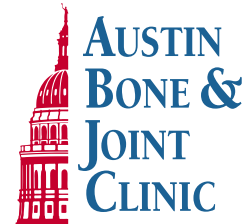
1401 Medical Parkway
Building C, Suite 100
Cedar Park, TX 78613

Round Rock - OACT

16020 Park Valley Dr.
Round Rock, TX 78681

Forest Creek - OACT

4112 Links Lane
Suite 101
Round Rock, TX 78664



Lockhart - GAO
1009 San Antonio St.
Lockhart, TX 78644

South Austin - ABJ
5625 Eiger Rd.
Suite 175
Austin, TX 78735

South Austin - GAO
5625 Eiger Rd.
Suite 175
Austin, TX 78735

Austin - ABJ
1015 East 32nd Street
Suite 101
Austin, TX 78705

James Casey St. - GAO
4310 James Casey St.
Suite 3-C
Austin, TX 78745

LaGrange - ABJ
657 E. Travis Street
Suite C
LaGrange, TX 78945