Center for Orthopaedics & Sports Medicine

AUTHORIZATION FOR RELEASE OF PROTECTED HEALTH INFORMATION

RELEASE COSM RECORDS

PATIENT NAME: _____(Please print) PATIENT DOB _____

I, _____(Patient Name) (*please print name)*
I, _____*(please print name)* as legal representative for the above named patient
☐Parent/Guardian ☐Authorized by Patient ☐Power of Attorney ☐Patient is incompetent

hereby authorize employees, medical staff members, or other agents of the *Center for Orthopaedics and Sports Medicine* (COSM) to disclose the following health information about me. ***(X-rays and/or office notes - specify dates and/or problems. (*List records needed here)**

DATES OF SERVICE	ANATOMY	X-RAYS
	☐ OFFICE NOTE ☐ OP NOTE ☐ OTHER	

☐ **I would like to pick up my records for my own use** **MY PHONE NUMBER IS** _____
☐ **SEND MY RECORDS TO:**
Provider/Facility: _____
ADDRESS: _____
_____
Phone Number: _____

☐ **COSM RECORDS (check all that apply below)**

☐ David T. Bizousky, MD	☐ Douglas S. Fugate, MD	☐ Craig C. McKirgan, DO	☐ Chong Min Park, MD	☐ Jagadeesha N. Shetty, MD	☐ David B. Wilson, MD	☐ Howard P. Miller, DPM	☐ Christa L. Pontani, CRNP	☐ Alan M. Keefe, MPA-C	☐ Tabitha L. Conrad, PA	☐ Greg C. Murray, MPA-C

☐**Center for Orthopaedics & Sports Medicine, 1265 Wayne Avenue, 119 Professional Center, Suite 307, Indiana, PA 15701**
Phone: 724.465.2676
☐**Center for Orthopaedics & Sports Medicine, 720 West Mahoning Street, Keystone Professional Center, Suite 200, Punxsutawney, PA 15767**
Phone: 814.938.0740
☐ **Center for Orthopaedics & Sports Medicine, 22868 Rt. 68. Suite 21, Clarion. PA 16214**
Phone: , 814.226.6573
☐ **COSM Rehab, 2128 Oakland Avenue, Indiana, PA 15701, Phone: 724.349.2276**
☐ **COSM Rehab, 720 West Mahoning Street, Punxsutawney, PA 15767, Phone: 814.938.4447**
☐ **COSM Rehab, 2354 Route 119, Homer City, PA 15748, Phone: 724.479.2259**

FOR THE FOLLOWING PURPOSES:
☐ At the request or direction of the signer of this request
☐ Other (describe) _____

THIS AUTHORIZATION EXPIRES:
☐On the following Date: ____/____/____ **(COSM authorizes only for 90 days from date of signature)**
☐When the following event occurs:_____

AUTHORIZATION OF FAXING OF RECORDS:
☐ I authorize this protected healthcare information to be faxed to_____
(COSM does not fax records unless it is a priority situation and authorized by management).
☐ I **do not** authorize any faxing of my protected healthcare information
☐ **Patient acknowledges receipt of COSM Authorization for the use or disclosure of health information. (initials)**

_____ _____
Patient Full Signature/Authorized Representative Signature Date

_____ _____
Witness Full Signature and Print Name Date

** If this form authorized the use or disclosure of psychotherapy notes, it may not be used to authorize the use or disclosure of any other Protected Health Information. A separate Authorization is needed for any other use or disclosure. Therefore, I authorize the release of psychiatric/psychotherapy records, mental health records and drug and alcohol treatment records under the same terms and conditions.

Records release_____(date) BY: _____(COSM initials)
☐ The following records were released: ☐ as stated above: _____

INITIALS OF STAFF HANDLING REQUEST _____ **Date** _____

Center for
Orthopaedics
& Sports Medicine

(Give to Signer of Release Form)

CENTER FOR ORTHOPAEDICS & SPORTS MEDICINE
AUTHORIZATION FOR THE USE OR DISCLOSURE
OF HEALTH INFORMATION

By signing a release Authorization, you are permitting the use and/or disclosure of your health information for the limited purposes(s), and in the limited manner, described in the form. Except as authorized by this form, we are required by federal law to maintain the privacy of your health information as described in our Notice of Privacy Practices.

REFUSAL OF SERVICE
If the only reason you have asked us to provide a health care service, is so that we can create information to be disclosed to a third party, we may refuse to provide the service if you refuse to sign this authorization. For example, if you have requested a drug test solely for the purpose of having the results disclosed to your employer, we may refuse to perform the drug test if you refuse to sign this Authorization permitting us to disclose the results to your employer.

Otherwise, your ability to receive treatment, payment, enrollment in a plan, or eligibility for a benefit does not depend on your signing this form. You may refuse to sign this form.
(Note to Employees Presenting This Form: If the treatment of the patient, payment for the patient's care, or enrollment of the patient in a health plan is conditioned on the patient signing this form, no use or disclosure other than that upon which treatment, payment, or enrollment has been conditioned can be authorized on this form. A separate authorization would be needed for any other use or disclosure.)

CONSEQUENCES OF SIGNING THIS FORM
Signing this Authorization may cause the health information used or disclosed pursuant to this Authorization to no longer receive the protections of federal privacy laws. Any person or organization to which your health information is disclosed pursuant to this Authorization might be able to legally re-disclose that information to others.

REVOCATION
You may revoke this Authorization at any time in writing except to the extent that we have already relied upon it in making a use or disclosure. Your written revocation will become effective when we have knowledge of it. If you are providing this Authorization to obtain insurance coverage, you may not have the right to revoke the Authorization to the extent that it pertains to the insurer's right under law to contest a claim under your insurance policy. If you wish to revoke this Authorization, please send your written request to:

Jamie L. Pride, Executive Director
Center for Orthopaedics & Sports Medicine
Privacy Officer/Contact Officer
1265 Wayne Avenue, Suite 307
Indiana, PA 15701

EXPIRATION
Once this Authorization has expired, we will no longer use or disclose your health information for the purpose listed in this Authorization unless you sign a new Authorization form.