AUTHORIZATION FOR RELEASE OF PROTECTED HEALTH INFORMATION

RELEASE COSM RECORDS

WORKER'S COMPENSATION AUTHORIZATION TO RELEASE W/C VISIT FORM (only)

Return fax: (724) 349-1830

PATIENT NAME: ____(Please print)

PATIENT DATE OF BIRTH ____________________________SOCIAL SECURITY (optional) ____________________________

I, ____(Patient Name) (*please print name*)

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. ***(Must specify date of injury and problem.)*** ***Will forward only the workers compensation visit form after a visit. All other records are sent with the billing to the insurance carrier as provided by the Pennsylvania Workers Compensation Act.)***

WORK INJURY and DATE of INJURY:

CLAIM NUMBER:

☐ **SEND MY RECORDS TO:** ☐ **Employer** ☐ **Case Manager/Company** ☐ **Third Party Administrator**

NOTE: Only one entity will receive a copy of the W/C Visit Form.

	Employer Name	Case Manager/Company	Third Party Administrator
Address			
Phone			
Fax			

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

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

☐ 119 Professional Center, Suite 307 ▪ 1265 Wayne Avenue ▪ Indiana, PA 15701 ▪ Phone: 724.465.2676 (COSM) ▪ Fax: 724.349.1830

☐ Keystone Professional Center, Suite 200 ▪ Punxsutawney, PA 15767 ▪ Phone: 824.938.0740 ▪ Fax: 814.938.0750

☐ Indiana at Chestnut Ridge ▪ 25 Colony Boulevard Suite 109 ▪ Blairsville, PA 15717 ▪ Phone: 724.465.2676 ▪ Fax: 724.349.1830

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 6 months from date of signature)**

AUTHORIZATION OF FAXING OF RECORDS:

I authorize this protected healthcare information to be faxed.

☐ **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.

INITIALS OF STAFF HANDLING REQUEST ________________Date ________________________

COSM
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.