PEDIATRIC ORTHOPEDIC ASSOCIATES OF SAN ANTONIO

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Authorization & Request to Release or Restrict Medical / Billing Information

I, _____, of _____
Patient (Parent or guardian if patient is a minor) Address City, State, Zip

hereby authorize and request the release of the following specific information from the Medical / Billing Records of patient Name:_____ Date of Birth: _____
Address:_____
City, State, Zip:_____ Phone: (_____)_____

SEND RECORDS FROM (select (#1) or (#2) only):
___ (1) POASA (letterhead above)
___ (2) Name / Organization: _____
Address: _____
City, State, Zip: _____
Fax No.(____)_____ Email _____

SEND RECORDS TO (select (#1) or (#2) only): by __ mail __ fax __ non-secure e-mail
___ (1) POASA (letterhead above)
___ (2) Name / Organization: _____
Address: _____
City, State, Zip: _____
Fax No. (____)_____ Email _____

For the purpose of: _____

__ **Do not Disclose Information to: _____**

My authorization / restriction extends only to those data elements / documents initialed below:

_____ Statements of charges or payments
_____ Records of visits (all visits)
_____ Progress Notes
_____ History & Physical Exam
_____ Operative Report
_____ Discharge Summary
_____ Consultation Reports
_____ All of the above
_____ Copies of records or reports provided to the above named physician
_____ Record of visit for a specific date or dates. Specific dates include or are limited to_____.
_____ Photographs, videotapes, digital or other images
_____ Mental Health and/or alcohol and drug abuse treatment
_____ Hepatitis Information
_____ AIDS (Acquired Immunodeficiency Syndrome) or HIV (Human Immunodeficiency Virus) information
_____ Other (Must be specific) _____

Restrictions to these dates of service:_____

This authorization is given freely with the understanding that:

1. Any and all records, whether written or oral or in electronic format, are confidential and cannot be disclosed without my prior written authorization, except as provided by law.
2. A photocopy or facsimile of this authorization is as valid as the original.
3. I may revoke this authorization at any time, which will not affect information already released. This authorization is valid for a one-year period from the date it is signed, unless stated here: _____.
4. Pediatric Orthopedic Associates of San Antonio, its employees, officers, and physicians are hereby released from any legal responsibility or liability for disclosure of the above information to the extent indicated and authorized herein.
5. Treatment, payment, enrollment or eligibility for benefits may not be conditioned upon obtaining this authorization.
6. Information used or disclosed pursuant to this authorization may be subject to re-disclosure by the recipient and is no longer protected.

_____ _____
Signature (Parent or guardian if patient is a minor) Date