



BOSTON HAND TO SHOULDER

REQUEST TO RELEASE PROTECTED HEALTH INFORMATION

All requests require 7-10 business days to complete.

Patient's Name: _____ Date of Birth: _____

Patient's Address: _____
Street City State Zip

Telephone Number: _____

By signing this authorization, I hereby authorize HandSurgery PC to release my protected health information including copies of my medical record of care and/or x-rays** received at Hand Surgery PC to the following persons at the locations/facilities listed below, for the purposes described:

☐ Medical Care ☐ Insurance ☐ Legal Matter ☐ Personal ☐ School ☐ Other (please specify) _____

Send to: _____ Attention: _____

Address: _____
Street City State Zip

Telephone Number: _____

Many of our patients allow family members such as their spouse, parents or others to call and request the results of tests and procedures. Under the requirements for H.I.P.P.A. we are not allowed to give this information to anyone without the patient's consent. If you wish to have your results released to family members you must sign this form. Signing this form will only give consent to release results to the family members indicated below. This consent form will not allow Hand Surgery PC to release any other information to these family members.

You have the right to revoke this consent, in writing, except where we have already made disclosures in reliance on your prior consent.

I authorize Hand Surgery PC to release my laboratory/radiology results and reports to the following individuals.

1. _____ Relation to Patient: _____

2. _____ Relation to Patient: _____

Date: _____

Signature of Individual or Legal Representative:

Relationship of legal representative to individual if minor: _____

** \$10.00 fee applies for x-ray