THE HAND & WRIST CENTER

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"RELEASE OF INFORMATION" AUTHORIZATION FORM

In compliance with the *Health Insurance Portability and Accountability Act* (HIPAA), our Center requires written identification of all entities the patient/legal guardian will give unlimited, permitted access to their Protected Health Information (PHI). PHI can include, but is not limited to, medical reports, laboratory reports, appointment information and financial/billing records. For further, detailed information regarding our Center's HIPAA practices, please refer to our HIPAA policy posted online at www.handwristcenter.com and/or our reference manual located at our Receptionary Desk.

NOTICE TO PATIENT/LEGAL GUARDIAN: Authorization to release PHI (to the patient, their legal guardian, their legal survivor, referring Physician, insurance carrier(s) and/or any other entity the patient/legal guardian designates as financially responsible for their services) is deemed to be "automatic" in nature and is a condition of being able to receive services by our Facility's healthcare providers. The patient/legal guardian reserves the right to submit to our Center (in writing) a request to prohibit the release of information to any entity listed above and/or below; however, our Center also reserves the right to deny service if it concludes that prohibiting such information will interfere in our ability to render services. ***The Hand & Wrist Center*** is not responsible for any subsequent distribution of the patient's PHI once it has been distributed to any of the above-listed and/or below-listed entities and/or their elected representatives.

E-MAIL DISCLAIMER: Please note that if the patient/legal guardian provides our Center with an e-mail address, the patient/legal guardian is providing ***The Hand & Wrist Center*** with automatic authorization to communicate medical (and account) information to the patient/legal guardian and/or any of their elected representatives, via that e-mail address. Additionally, this authorization allows our Center to e-mail medical information to any healthcare provider directly involved in the care of the patient (and who elects to communicate via e-mail). If the patient/legal guardian elects not to have any information communicated via e-mail, the patient/legal guardian is hereby instructed to not provide our Center with an e-mail address and to provide our Center with written notification prohibiting the sharing of the patient's information electronically with any entity.

RIGHT TO REVOKE/CHANGE AUTHORIZATION: The patient/legal guardian may revoke or change any or all parts of their designations below at any time by completing a new ***Release of Information*** form and submitting it to the ***The Hand & Wrist Center***. The patient/legal guardian acknowledges that any revocations or other changes made to this authorization are effective the date each new form is completed and signed. Revocations and other changes are not retroactive.

PATIENT ACKNOWLEDGEMENT: The following list will serve as formal acknowledgement and authorization, on my (patient/legal guardian) behalf, to release and/or discuss any/all information related to my medical condition and treatment with:

☐ **Me (the patient/legal guardian) ONLY**

☐ **Me (the patient/legal guardian) AND (check boxes and list the first/last name and telephone number by the applicable):**

- ☐ **Spouse/Domestic Partner:_____Tel: (_____)_____-_____**
- ☐ **Paternal/Maternal Parent:_____Tel: (_____)_____-_____**
- ☐ **Brother / Sister (Sibling): _____Tel: (_____)_____-_____**
- ☐ **Son / Daughter: _____Tel: (_____)_____-_____**
- ☐ **Other Family Member: _____Tel: (_____)_____-_____**
- ☐ **Attorney: _____Tel: (_____)_____-_____**
- ☐ **Other: _____Tel: (_____)_____-_____**

PATIENT NAME (PRINTED): _____

LEGAL GUARDIAN NAME (PRINTED): _____ ***RELATIONSHIP:** _____

PATIENT/LEGAL GUARDIAN SIGNATURE: _____ **DATE:** _____