Internal:___
External:___

Authorization for Disclosure of Health Information

I, the undersigned, authorize **Hampton Roads Orthopaedics & Sports Medicine** and its affiliates to release my health information as noted below:

Please send completed form (signature required) to: request@bhsconnect.net or fax to (513) 653-0778.

(forms that are not completed fully will delay records release)

Patient Information

*REQUIRED

Patient Full Name:* _____

Date of Birth:* _____ Phone Number:* _____

Is this request due to a transfer?* ☐ Yes ☐ No

Release Information To

Requester Name:* _____ Phone:* _____

☐ Email:* _____ ☐ Fax: _____

Address:* _____ City:* _____ State:* _____ Zip:* _____

Purpose of Request:* ☐ Legal ☐ Disability ☐ Insurance ☐ Personal ☐ Treatment ☐ Transfer/Reason _____

☐ Other:_____

Information to be Released

Please specify the information to be released:

☐ Date Range: _____to include the following:

☐ Office notes ☐ Diagnostic reports ☐ Operative reports ☐ Itemized billing statement

☐ X-ray/MRI Films ☐ Complete record w/films ☐ Complete record w/o films

I understand that HROSM uses a third party records processing company called BHS CONNECT and I will receive an invoice from BHS CONNECT per Virginia Statutes. Payment is made directly to BHS CONNECT. Questions about your request or invoice can be answered by calling BHS CONNECT at (513) 898-1044.

Authorization to Release Protected

Please complete the check boxes below indicating how protected information should be handled even if the categories do not necessarily apply to the patient's medical records.

Check Here

I ☐ **DO** want information about **Mental Health** released

I ☐ **DO** want information about **HIV Tests** & **Related Information** released want

I ☐ **DO** information about **Alcohol and/or Substance Abuse** released

Patient's Signature* _____ **Date:** _____

(**Required** for all patients 18 years and older. 18 years and older for psychiatric records, 14 years and older for substance use records)

Signature of Parent or Legal Guardian _____ **Date:** _____

(Required for all patients under the age of 18 unless otherwise allowed by law. If not the parent, legal representation documentation must be supplied)

This authorization will expire 1 year from the date appearing above. I understand that I may revoke this authorization at any time by notifying the Health Information Management department in writing, but if I do, it will not have any effect on the actions the clinic took before it received the revocation.

I understand that under the applicable law, the information used or described pursuant to this authorization may be subject to disclosure by the recipient and no longer subject to the protections of the privacy standard. I understand that my treatment or continued treatment by HROSM and its affiliates is in no way conditioned on whether or not I sign the authorization and that I may refuse to sign it. I understand that I may inspect or copy the information that is used or disclosed.