BEACON
Orthopaedics & Sports Medicine

sharecare | HEALTH DATA SERVICES
Formerly BACTES

AUTHORIZATION FOR RELEASE OF PROTECTED HEALTH INFORMATION

All sections must be completed or form will be returned. Requests take approx. seven business days to process. Rush requests cannot be honored. Fax form to: 513-354-3705.

PATIENT INFO: Name: _____ Date of birth: _____

Address: _____

Phone: _____ Reason for request: _____

INFORMATION TO BE RELEASED: I hereby request and authorize Beacon Orthopaedics & Sports Medicine, Ltd. and Beacon Surgery Center to release the protected health information indicated below. I understand and acknowledge that this may include treatment for physical and mental illness, alcohol/drug abuse, and HIV/AIDS test results or diagnoses. Mark all that apply.

1. DATES OF TREATMENT TO RELEASED: From (Date) _____ to _____
2. Please release (mark all that apply):

___Office Visit Notes	___Imaging Reports	___Operative Reports	___MRI Images**
___Lab Results	___Procedure Notes	___Itemized Billing	___Xray Images**
___Physical Therapy			___CT Images**
___Other (be specific) _____			

RELEASE INFORMATION TO (Fill in Name – then select <u>one</u> of the four options. **Images cannot be faxed or emailed.)

Name of Provider/Place/Person: _____

1. Mail to: Address: _____City/ST/Zip: _____
2. Fax to: _____
3. Email address (if applicable): _____
4. I want to pick my records up at this Beacon location: ____Summit Woods ____West ____Northern Kentucky

EXPIRATION, PATIENT RIGHTS AND FEES

This authorization will expire one year from the date signed below (unless I specify an earlier date here: _____). I understand I may revoke this authorization at any time, in writing, and that revocation will not apply to information that has already been released. Information used or disclosed as per this authorization may be re-disclosed by the provider/ place/person receiving the information and may no longer be protected by federal or state law. Signing this authorization is voluntary. I can refuse to sign this authorization. My right to health care treatment is not conditioned on this authorization. I understand that I may request a copy of this authorization, that there may be a charge for the requested information, and that information sent via unencrypted email could be read by a third party.

SIGNATURE

X_____ _____

Signature of Patient or Legally Authorized Representative* Date

_____

*IF APPLICABLE: Printed Name and Relationship of Legally Authorized Representative. If patient is over the age of 18, please provide appropriate documentation such as copy of Medical Power of Attorney or court order.

Updated Oct 2018 *Dated request processed: _____ By: _____*