Release of Protected Health Information

Benton Franklin Orthopedic Associates, P.L.L.C.
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Kennewick, WA 99336
Phone: (509) 586-2828 • Fax: (509) 586-2525

Patient Name: _____ Date of Birth: _____

I hereby authorize _____ to release my individually identifiable health information as described below.

Name and address of organization to receive information:

☐ Addressee (Benton Franklin Orthopedic Associates, P.L.L.C.)

☐ Authorization to fax to: (_____)_____

_____

_____

Purpose for which records will be used: _____

_____

☑ Medical records from _____ to _____

☐ Laboratory Reports _____

☐ X-Ray Reports _____

☐ X-Rays _____

☐ EDGs _____

☐ Exclusions: _____

☐ _____

- I understand that I have the right to a copy of this release, and that I may inspect or copy the information to be used or disclosed (fees will be assessed for the copying of records).
- This authorization is voluntary.
- This authorization will expire _____ (e.g., 60 days) from the date of my signature below.

Signature _____ Date _____

Witness Signature _____

I understand that my expressed consent is required to release any health care information relating to testing, diagnosis, and/or treatment for HIV (AIDS virus), sexually transmitted diseases, psychiatric disorder/mental health, or drug and/or alcohol use.

I authorize the above-mentioned information to be released.

Signature _____