Atlantic ORTHOPAEDICS & SPORTS MEDICINE™

1900 Lafayette Road Suite A Portsmouth, NH 03801

16 Hospital Drive York, ME 03904

Telephone: (603) 431-1121 Fax: (603) 431-9147

☐ **I authorize Atlantic Orthopaedics and Sports Medicine to REQUEST protected health information from the Medical Records of:**

☐ **I authorize Atlantic Orthopaedics and Sports Medicine to RELEASE protected health information from the Medical Records of:**

Patient Name	**Date of Birth**	**Telephone**

Address	**City**	**State**	**Zip Code**

Provider/Company	**Telephone**	**Fax Number**

Address	**City**	**State**	**Zip Code**

☐ **This authorization will remain in effect for 1 year from date signed.**

☐ **This authorization will remain in effect until:** _____

Information to be released:

☐ XRAY Disk and Report	☐ Hospital Records	☐ Sexually Transmitted Disease
☐ Treatments, Tests	☐ Consultations	☐ Mental Health
☐ Laboratory Reports	☐ Allergy Reports	☐ Alcoholism
☐ Surgical Reports	☐ HIV Test Results	☐ Drug Abuse

☐ Other: _____

☐ Records are being requested for the purposes of: _____

I understand that the health information redisclosed as a result of this authorization may no longer be protected by the Federal Privacy.

Standards and my health information may be re disclosed without obtaining my authorization.

I understand that I have the right to:

*Receive a Copy of this Authorization

*Refuse to sign this Authorization and that treatment, payment and enrollment in a health plan or eligibility for my healthcare benefits may not be contingent on my signed authorization.

*Revoke this Authorization, except to the extent that Sports Medicine Atlantic Orthopaedics and any of it's employees have already made reference to its authorization.

Signature of Patient or Atlantic Orthopaedics Representative	**Date**