AUTHORIZATION FOR RELEASE OF MEDICAL RECORDS

Osteoporosis & Arthritis Center, Inc.
Dr. Lane B. Scheiber II, MD, FACR
osteoporosisandarthritiscenter.com

NAME:_____ DOB:_____
STREET ADDRESS:_____ LAST 4 DIGITS OF SSN: XXX-XX- _____
CITY:_____STATE:_____ZIP CODE:_____

I authorize Osteoporosis & Arthritis Center, Inc. and Lane B. Scheiber II, MD to release medical records to:
WRITE IN YOUR NAME OR A PHYSICIAN OR AGENCY:_____
STREET ADDRESS:_____
CITY:_____STATE:_____ZIP CODE:_____

SPECIFIC RECORDS DATED FROM:_____ TO:_____
This disclosure is for the purpose of:_____
(e.g., further care, insurance claim, personal, legal counsel, etc.)

Email this completed form to: records@osteoporosisandarthritiscenter.com

Records release will be standard service charge of $1.00 per page. If records are to be mailed to an address, an additional charge of $10.00 per every fifty pages will be applied. Please provide credit card information below:

Credit card number:_____ Name on the card:_____
Expiration: _____ Security Code:_____
Signature of the Credit Card holder to authorize above-mentioned charges:_____

Records to be released to <u>one</u> of the following:

(1) Address:	(2) Fax	(3) EMAIL:
Name:_____	Name:_____	Name:_____
Address:_____	Fax Number:_____	Email:_____
City:_____		
State:_____ Zip code:_____		

I understand that my medical record may include information relating to sexually transmitted disease, acquired immunodeficiency syndrome (AIDS), or human immunodeficiency virus (HIV). It may also include information regarding behavioral or mental health services, development disabilities, or treatment or use of alcohol and/or drug use or drug abuse or other sensitive personal information.
I understand the records I receive are to be to be stored and safeguarded per HIPAA standards. I release the Osteoporosis & Arthritis Center, Inc. and Dr. Lane B. Scheiber II, MD from any liability associated with mishandling or potentially mishandling or disclosing medical records by myself or a third party that I authorized release to.
I understand a request for medical records may take 30 days to be enacted upon due to accessing record storage.
I have the right to inspect or obtain a copy of the records that are to be disclosed. I understand any disclosure of information carries with it the potential for un-authorized re-disclosure and the information may not be protected by federal confidentiality rules and I release Osteoporosis & Arthritis Center, Inc. and Dr. Lane B. Scheiber II, MD from any liability regarding disclosure created by a third party that I authorized release of records to.
I understand that I may revoke this authorization at any time. I understand if I revoke this authorization, I must do so in writing and present the written revocation to Osteoporosis & Arthritis Center, Inc. I understand the revocation will not apply to information that has already been released in response to this authorization.

This authorization will expire on the following date or event:_____
(if I do not specify an expiration date, this authorization will expire in 60 days post date of signature)

Authorizing Signature of Patient:_____Date:_____
Signature and Seal of Notary:_____ Date:_____
(*Patient signature must be notarized for records to be released.)