

**Medical Provider's Name:**

Augusta Aiken Orthopedic Specialists  
Georgia Fax # 706-860-7686  
South Carolina Fax: 803-649-0543

Please Deliver Records:

- Electronic Delivery\*\*
- Mail
- Patient Pick Up

**Authorization for Release of Protected Health Information**

Patient Name (at time of treatment): \_\_\_\_\_

Date of Birth: \_\_\_\_\_ Social Security Number:   xxx   -   xx   - \_\_\_\_\_

Address: \_\_\_\_\_

Telephone #: \_\_\_\_\_ AAOS Account #: \_\_\_\_\_

**I authorize the above named provider to release my protected health information to:**

Recipient Name: \_\_\_\_\_ Attention to: \_\_\_\_\_

Street Address: \_\_\_\_\_

City/State/Zip Code: \_\_\_\_\_

Fax: \_\_\_\_\_ \*\*Email: \_\_\_\_\_

*(required for electronic delivery only)*

Information for treatment period: From (date): \_\_\_\_\_ to (date): \_\_\_\_\_

Information to be released (please check all that apply):

- Standard Record Set (office notes, labs, consults, op notes, imaging, PT)
- Office Notes  Imaging Reports  Other \_\_\_\_\_
- Operative Notes  Imaging CD (CMI-\$25)\*

This information is being requested for the following purpose(s): \_\_\_\_\_

**Sensitive Information:** I understand that my record may include information relating to AIDS or HIV, psychiatric care, psychological assessment, behavioral and/or mental health services, sexually transmitted diseases, alcohol and/or drug abuse and this information will be released.

**Re-disclosure:** I understand that any disclosure of information carries with it the potential for re-disclosure and that the information then may not be protected by federal confidentiality rules.

**Right to revoke:** I understand that I have the right to revoke this authorization at any time. I understand that my revocation must be in writing to the above medical provider and that the revocation will not apply to information already released based on this information.

**Expiration:** I understand that this authorization will expire twelve (12) months after signed unless an earlier date is specified here: \_\_\_\_\_

**Services:** I understand that refusal to sign this authorization cannot be used as a reason for denial of services or benefits.

\_\_\_\_\_  
Signature of Patient or Legal Representative

\_\_\_\_\_  
Date

\_\_\_\_\_  
Description of Legal Representative's Authority  
(Attach necessary documents)

This facility has partnered with CIOX health to process and fulfill your request for a copy of your medical record. Due to the strict procedural and highly regulated steps involved in this process, known as the release of information process, there are costs associated and, therefore, a fee is charged for this service. (Fee schedule available upon request). Payment for records is not accepted on site; you will receive an invoice from CiOX Health via mail, which can be paid upon receipt.