Fredericksburg Orthopaedic Associates, PC
3310 Fall Hill Avenue
Fredericksburg, VA 22401
Fax 540-310-0100

Authorization to Use or Disclose Protected Health Information (PHI)

Patient Name: _____ Date of Birth: _____

Daytime Phone Number: _____

I have requested a copy of my medical records and understand Ciox Health will, (under agreement with Fredericksburg Orthopaedic Associates, P.C.), facilitate the realease of my records based on my authorized request.

I understand I will receive an email from Ciox Health, at the email address provided below, that will include detailed instructions on how to access my electronic records via a secure web portal. Once I have received the email notification from Ciox Health, the medical record(s) will be available via the web portal for 30 days.

Email Address for record delivery: _____

List any exceptions unavailable for release _____
_____

The patient has the right to revoke this authorization. In order to be effective, it must be in writing. The revocation will take effect on the date both the patient and the practice have signed it. It must include patient's name, address, and phone number. The patient's reason for revocation, the patient's signature and the date of revocation must be included.

Fredericksburg Orthopaedic Associates, PC will accept revocations of this authorization by certified mail only. This revocation must be sent to the attention of the Privacy Officer, Ahmad Chaudhary at Fredericksburg Orthopaedic Associates, PC 3310 Fall Hill Avenue, Fredericksburg, VA 22401. It is not effective until received and signed by the Privacy Officer. I fully understand and accept the terms of this authorization.

I also acknowledge receipt of the notice of Information Practices provided to me.

_____ _____
Patient or Legal Guardian Date

PT# _____