Gavin Orthopaedics, LLC
The Sport & Spine Institute
15 Moss Creek Village • Hilton Head, SC 29926
843-681-5077

MEDICAL RECORDS REQUEST

To comply with the requirements of the Health Insurance Portability and Accountability Act (HIPAA) 1996, Gavin Orthopaedics is requesting your authorization for use or release of health information.

Please complete with black or blue ink or type:

Patient Last Name: _____ First Name:_____ MI:_____

Date of Birth: _____ SS No:_____

I hereby authorize disclosure of my health information under the following conditions and limitations:

1. Information may be disclosed to: Name: _____
   Address: _____
   City: _____ St:_____ Zip:_____
2. Information may be disclosed by: Name/Entity: _____
3. Information to be disclosed: State type(s) of information that may be disclosed:

   _____ My Complete medical records or
   _____ Operative Reports
   _____ X-ray reports
   _____ Photographs, video tapes, digital or other images, media
   _____ Other (please specify)_____
4. Uses and limitations on information: State specific uses and limitations to information by recipient
5. Expiration Date of Authorization: State date on which authorization for use or disclosure expires. Should an actual date not be provided, Gavin Orthopaedics will accept this signed form for seven years from date of signature. Research expiration date can be “none”.
   _____/_____/_____
6. Authorization granted by:

Signature: _____Print Name:_____

Date: _____ Relationship to Patient: _____ Self _____ Other_____

Patient, spouse, legal representative, or beneficiary (Patient’s spouse may authorize disclosure of the patient’s health information only when the information is for the sole purpose of processing an application for health insurance for enrollment in a health service plan or an employee benefit plan and where the patient is to be an enrolled spouse or dependant under this policy or plan)

7. I understand that if the person or entity that receives the information is not a health care provider or health plan covered by federal privacy regulation, the information described above may be re-disclosed and no longer protected by those regulations.

Signature: _____Print Name:_____

Date:_____