Hinge Health HIPAA Form H004-2010.1

Patient Authorization for Release of Medical Records for Continuity of Care

Name: _____

Date of Birth: _____ / _____ / _____

Address: _____

City: _____ State: _____

ZIP: _____ Telephone: _____

I, or my authorized representative, request that health information regarding my care and treatment be released as set forth on this form. In accordance with the Health Insurance Portability and Accountability Act of 1996, as codified at 42 U.S.C. §1320d et seq. ("HIPAA") and the Health Insurance Technology for Economic and Clinical Health Act of 2009 ("HITECH"), I hereby authorize the below providers to RELEASE and DISCLOSE my medical records related to my musculoskeletal health conditions and treatment, including but not limited to patient histories, office notes, test results, radiology studies, pathology slides, films, referrals, consults, billing records, insurance records, records sent to you by other healthcare providers, and any other protected health information to Hinge Health, my healthcare provider that requires these records to continue my care and provide me with treatment, review or consultation:

[fill in names and addresses for each healthcare provider you want to release medical records]

PROVIDER NAME ADDRESS

1) _____

2) _____

3) _____

4) _____

5) _____

I do NOT authorize the release of medical records containing any of the following:

Substance Abuse Information
Psychiatric/Mental Health Information
HIV/AIDS Information

This authorization is fully understood and is made voluntarily on my part. I understand that my healthcare provider may not condition treatment or payment upon execution of this authorization. However, if I refuse to sign this authorization, then my healthcare provider may not be able to obtain my medical information. I understand that the information may be redisclosed by the recipient and may no longer be protected by law. I hereby release my above listed healthcare provider and any of their HIPAA Business Associates involved in collecting my records from any legal liability that may arise out of the collection, gathering, scanning, digitizing, and release of the information requested. By signing below I express my intent to be bound by this authorization. I understand that I may revoke this authorization at any time except to the extent that action based on this authorization has been taken. Cancellation of this authorization must be made in writing and faxed to 866-920-5565. I understand that if I wish to review the Notice of Privacy Practices I may request a copy by contacting the telephone number below and one will be provided to me at no cost.

This authorization expires one (1) year from the date it has been signed.

_____ _____

Patient or Legal Guardian Signature Date Signed

If Legal Guardian, please describe authority to sign: _____

Please EMAIL to: Intake@PatientIntakeGroup.com
Or FAX to: 415-373-1719
For assistance call: 844-365-1625