BONE AND JOINT SURGERY ASSOCIATES, P.A.

Farbod Malek, M.D.

Tel. 210.865.9200
Fax 210.641.2805

Farbod Malek, M.D.
Bone & Joint Surgery
Associates P.A.

HIPPA COMPLIANT AUTHORIZATION FOR THE RELEASE OF PATIENT INFORMATION

To: _____

Address: _____

RE:

Patient Name: _____

DOB: _____ SS#: _____

I authorize and request the disclosure of all protected information for the purpose of review and evaluation in connection of my medical care. I expressly request that the designated record custodian of all covered entities under HIPPA identified above disclose full and complete medical information including the following:

- ☐ All medical records, including but not limited to: office notes, face sheets, history and physical, consultation notes, inpatient, outpatient and emergency room treatment, all clinical charts, reports, order sheets, progress notes, treatment plans, discharge summaries, test results and any records received by other medical providers.
- ☐ All physical, occupational and rehab requests, consultations and progress notes.
- ☐ All laboratory, histology, cytology, pathology; radiology records and films including CT scan, MRI, EMG, and bone scan.

You are authorized to release the above records to Bone and Joint Surgery Associates, PA and Dr. Farbod Malek at 2122 Babcock Rd. Suite 101, San Antonio, Texas 78229, or NIX location 5307 Broadway Suite 120, San Antonio, TX 78209 telephone (210) 865-9200, fax (210) 641-2805.

Any facsimile, or copy of the authorization shall authorize you to release the records requested herein.

Signature of Patient: _____ Date: _____

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ACKNOWLEDGEMENT OF RECEIPT OF NOTICE OF PRIVACY PRACTICES

By signing this form, I acknowledge receipt of the Notice of Privacy Practices of Bone and Joint Surgery Associates. The Notice of Privacy Practices provides information how Bone & Joint Surgery Associates may use and disclose my protected health information.

I acknowledge receipt of the Notice of Privacy Practices of Bone & Joint Surgery Associates.

_____Date: _____

(patient/parent/conservator/guardian)

FOR BONE & JOINT SURGERY ASSOCIATES USE ONLY

Inability to Obtain Acknowledgement

To be completed only if no signature is obtained. If it is not possible to obtain the patient's acknowledgement, describe the good faith efforts made to obtain the patient's

acknowledgement, and the reasons why the acknowledgement was not obtained:

_____

_____

_____

_____

Signature of Bone & Joint Surgery Associates representative:

_____Date_____