Authorization to Release Protected Health Information (PHI) Klamath Orthopedic Clinic 2200 Bryant Williams Dr. Suite 1 Klamath Falls, OR 97601 CHART#_

|--|

Patient Name		Maiden Name	SS#
Date of Birth	Home Phone	Ce l l/Work	
Address		City/State/Zip	
A) I hereby authorize records from:			by mail, fax, or email sent to: Physician Office as listed below
Name KLAMATH ORTHOPEDIC CLINIC Address 2200 BRYANT WILLIAMS DR, STE 1		☐ Email	
		Physician Name	
City/State/ZipKLAMATH FALLS, OR 97601		Address City/State/Zip	
Phone# <u>541-884-7746</u> Fax#_	541-274-5745	·	_FAX#
C) For the purpose of:			to
Litigation	Disability/SSI	Physician Office Notes Operative/Procedure Reports	☐ Operative/Procedure Reports
Insurance Self/Personal Copy	Work Comp Other	I	ports Radiology/X-ray/MRI Images CD*
Continuity of Care	Transfer of Care (Permanently Leaving)	I <u> </u>	Financial Statement/Billing
sign this form in order to assur disclosure and the information information, I can contact the a I understand that the immunodeficiency syndrome (health services, and treatment I understand that I had in writing and present my writted that has already been released when the law provides my insu This authorization processary for future records	e treatment. I understand the may not be protected by uthorized individual or organ information in my medical (AIDS), or human immunode for alcohol and drug abuse, we a right to revoke this author revocation to the Medical din response to this author rer with the right to contest a pertains to records for data. This request is valid for attion provided on the	at any disclosure of information car federal confidentiality rules. If I hazation making disclosure. The record may include information related increased in the records of the records Department. I understand ization. I understand that the revolutional includes a claim under my policy. The ses on or prior to my signed records of the r	can refuse to sign this authorization. I need not rries with it the potential for an unauthorized renave questions about disclosure of my health ating to sexually transmitted disease, acquired include information about behavioral or mental distance that if I revoke this authorization, I must do so that the revocation will not apply to information exation will not apply to my insurance company ords request and a new records request is the revocation will not apply to my insurance company ords request and a new records request is the revocation will not apply to my insurance company ords request and a new records request is the revocation will not apply to my insurance company ords request and a new records request is the revocation will not apply to my insurance company ords request and a new records request is the revocation will not apply to my insurance company or the revocation will not app
tamiliar with and fu ll y i	understand the term	s and conditions of this	authorization. **Subject to Fees
(Date)	(Signature of	f Patient/Parent/Guardian or Aut	

**PLEASE READ Fee Information: Klamath Orthopedic Clinic contracts with Verisma Systems, Inc. to copy and provide all medical records requested from our office. Verisma Systems, Inc reserves the right to charge the medical record state fee structure as set forth in the state statute. Copy charges plus postage will be invoiced to you from Verisma Systems, Inc with all of the necessary directions to receive your records. By signing this authorization, you are agreeing to pay Verisma Systems, Inc for your records. In the case of continuity of care or personal copy to patient, Verisma Systems, Inc may transfer a minimal portion of your records as a courtesy.

Verisma Systems, Inc: 816.437.9134 2023 Authorization Form