Orthoclinic
610 Chestnut Street
South Charleston, WV 25309
Phone: 304-767-7790
Fax: 304-766-7566

Orthoclinic utilizes an Electronic Medical Record system that can retrieve information about prescriptions that have been paid for by insurance. Retrieving that history gives the physicians complete information that will assist them in providing the best care and preventing unwanted prescription interactions. Please select one of the following options:

☐ I authorize Orthoclinic to retrieve my prescription history

☐ I do not authorize Orthoclinic to retrieve my prescription history

May Orthoclinic and/or members of the office staff release medical information to specified persons other than you?

Yes _____ No _____

If yes, please specify persons(s):

Authorized Person	Relationship	Phone Number
_____	_____	_____
_____	_____	_____

What information may be released?

Lab Results	Yes:	No:
X-ray Reports	Yes:	No:
Medications	Yes:	No:
Medical Status	Yes:	No:
Appointments	Yes:	No:

Emergency Contact Person: _____ Phone Number: _____

I understand as part of my continuing healthcare, my physician maintains medical records in his/her office, which contain my health history, symptoms, examination test results, diagnosis, and treatment plans, to be used as a basis for planning my care and treatment, and that this information may be released to my other physicians/healthcare providers.

I understand that I have the right to request restrictions as to how my medical records may be used or disclosed.

I understand my physician keeps on premises a copy of the "Notice of Privacy Practices for Protected Health Information" which provides a more complete description of the uses and disclosures of my medical records, and I have been provided the opportunity to review this document prior to signing this consent, and that a written copy will be provided to me upon request.

I understand that my physician has the right to change this policy and that I will be notified in writing prior to any changes taking effect.

I understand this document is a part of my permanent medical record, and I may make changes regarding disclosure of my health information at any time. I also understand I will need to notify my physician in writing of these changes.

_____ _____

Patient Signature Date

_____ _____

Printed Name Date of Birth