ORTHOPAEDIC ASSOCIATES, INC.

AUTHORIZATION FOR THE USE OR DISCLOSURE OF PROTECTED HEALTH INFORMATION

As required by the Health Insurance Portability and Accountability Act of 1996 and required by April 14, 2003, Orthopaedic Associates, Inc. may not use or disclose your health information except as provided in our Notice of Privacy Practices without your authorization. Your signature on this form indicates that you are giving permission for the use and/or disclosure of protected health information described below. You may revoke this authorization at any time by signing the dating the revocation section identified below.

AUTHORIZATION SECTION

I hereby give my consent to this practice to use and disclose my protected health information for the purpose of treatment, payment, and operations of my healthcare and this practice. This consent includes contact and discussion with other healthcare professionals for my care and treatment.

I, ____, (Patient Name) hereby authorize the use and/or disclosure(s) of the following
PLEASE PRINT
protected health information that pertains to me: my medical records and diagnoses, including but not limited to all lab / x-ray reports, progress reports and other information I have identified below:

SECTION A – INDIVIDUALS ALLOWED TO HAVE ACCESS TO MY PROTECTED HEALTH INFORMATION

I authorize the following person(s) and/or entity(ies) to be personally involved (including telephone calls) and receive my protected health information during the course of my medical care until revoke by me in writing: **(Please circle all that apply)**

Spouse Children Parents Step Parent Ex-Spouse Coach/Trainer Attorney Employer

Other ____
Be specific

SECTION B – RELEASE OF MEDICAL RECORDS AND/OR X-RAYS

I authorize the following person(s) and/or entity(ies) to receive my protected health information : **(Please Circle)**

Self Physician / Medical Provider Attorney Employer Other__________________________________

Name:____

Address____City___________________________________Zip__________

I understand that I have a right to:

- Refuse to sign this authorization. I further understand that my ability to obtain treatment will not depend in any way on whether I sign this authorization or not.
- To inspect and to obtain a copy of any protected health information disclosed relating to this authorization
- Receive a signed copy of this authorization.

The use or disclosure requested under this authorization will result in direct or indirect payment to Orthopaedic Associates, Inc. from a third party if applicable.

PATIENT SIGNATURE

Print Name____
(Relationship if not patient)

Signature____Date_____________________________

REVOCATION

I hereby revoke this authorization. I further understand that any such revocation does not apply to the extent that the person(s) and/or entity(ies) authorized to use or disclose my protected health information have already acted in reliance on this authorization

____
Signature Date
If not patient, Relationship____