

**Please use BLACK INK**

## AUTHORIZATION FOR USE OR DISCLOSURE OF HEALTH INFORMATION

I hereby authorize the use and disclosure of individually identifiable health information relating to me, which is also called "protected health information" under HIPAA's Privacy Rule to be used as described below.

**Specific description of the information to be used or disclosed:**

- ★ **Dates of service** (please check only **one**):
- ALL** - Check the box if you have **no restrictions** on disclosure of information
- RESTRICTED** - Do NOT disclose treatment information from \_\_\_\_\_ (begin date) to \_\_\_\_\_ (end date)

Person or job title(s) of persons authorized to make the use of disclosure:

\_\_\_\_\_*OSMC*\_\_\_\_\_ (Example: Physicians & Staff)

Person or job title(s) of persons authorized to receive or use the disclosure:

\_\_\_\_\_*FAMILY*\_\_\_\_\_ (Example: Spouse, son, other)

The protected health information will be used and/or disclosed for the following purposes:

\_\_\_\_\_*AT MY REQUEST*\_\_\_\_\_ (Example: At my request)

- ★ **The person making the request is (check one):**     The individual     Representative for the individual

I understand that if the person or entity receiving this information is not a health plan or health care provider covered by federal privacy regulations, the information may be re-disclosed by the recipient and may no longer be protected by federal or state law.

I understand that I may revoke this authorization at any time by notifying **Orthopaedic and Sports Medicine Center (O.S.M.C.)** in writing and that if I choose to do so, my request to revoke will not affect any actions taken by **O.S.M.C.** before receiving my revocation.

I understand that I may refuse to sign this authorization. My refusal does not affect my treatment, payment, or eligibility for benefits.

This authorization expires one year after date signed.

- ★ **Name of patient:** \_\_\_\_\_
- Signature of patient:** \_\_\_\_\_
- Date:** \_\_\_\_\_
- Patient's date of birth:** \_\_\_\_\_

**If a personal representative is making the request on behalf of the patient:**

Name of personal representative: \_\_\_\_\_

Describe personal representative's relationship (parent, guardian, executor, etc): \_\_\_\_\_

Signature of personal representative: \_\_\_\_\_

Date: \_\_\_\_\_