DOC ORTHOPAEDICS & sports medicine

AUTHORIZATION FOR USE AND DISCLOSURE OF PROTECTED HEALTH INFORMATION

Patient Acct: _____ **SSN:** _____

Patient Name: _____ **Date of Birth:** _____

Patient Address: _____

By signing below, you hereby authorize us to use or disclose information about yourself (or another person for whom you have the authority to sign) that is protected under federal law, for the sole purpose and time period described below. *Y*ou may refuse to sign this authorization. Subject to certain exceptions, you have the right to inspect and copy the protected health information.

Information to be used or disclosed (must be identified in a specific and meaningful fashion); and purpose of the use and disclosure:

_____

_____

_____

Information that *may not be used or disclosed:*

_____

_____

The name or other specific identification of the person(s), or class of persons*, authorized to make the requested use or disclosure:*

_____

_____

The name or other specific identification of the person(s), or class or persons, to whom Decatur Orthopaedic Clinic *may make the requested use or disclosure:*

_____

_____

Expiration date or an expiration event (must relate to the individual or the purpose of the use or disclosure):

_____

This information about you is protected under federal law, and you have the right to revoke this authorization in writing. Please be advised, however that any revocation will be effective only to the extent we have not already taken action in reliance on your authorization. By signing below, you recognize that the protected health information used or disclosed pursuant to this authorization may be subject to re-disclosure by the recipient of this disclosure and may no longer be protected under federal law. We will not condition treatment based on your authorization. You may refuse to sign the authorization.

_____ _____

Patient Signature or Personal Representative Date

As a personal representative, I have authority to act for the individual because I am:

_____

Witness: _____