

**AUTHORIZATION  
 FOR THE USE OR DISCLOSURE  
 OF HEALTH INFORMATION**

Date needed by: \_\_\_\_\_  
 To be picked up  
 To be mailed  
 To be faxed to \_\_\_\_\_

<b>Patient Identification</b>	Name: _____ Date of Birth: _____ Address: _____ Phone: _____ Cell: _____ City/State/Zip: _____ Maiden/Previous Names/Nickname: _____ Social Security Number: _____
<b>Provider</b> <small>(Who is releasing information?)</small>	Provider/Facility Name: _____ Address: _____ Phone: _____ City/State/Zip: _____
<b>Disclose Information To:</b> <small>(Where is information to be sent?)</small>	Name/Facility: _____ Address: _____ City/State/Zip: _____ Phone: _____ Fax: _____ To assure confidentiality, it is the policy of Orthopedic Institute to send records via first-class mail. Orthopedic Institute will transmit records via facsimile only when requested and expressly authorized by the patient.
<b>Information to be Disclosed</b>	<input type="checkbox"/> All Records <input type="checkbox"/> Lab Data <input type="checkbox"/> Other: _____ <input type="checkbox"/> Clinic Progress Notes <input type="checkbox"/> Pathology Reports <input type="checkbox"/> X-ray Films & Reports
<b>Purpose of Disclosure</b> <small>(Please Be Specific)</small>	<input type="checkbox"/> Continuing Medical Care <input type="checkbox"/> Consult / Second Opinion <input type="checkbox"/> Out of town move <input type="checkbox"/> Insurance Claim <input type="checkbox"/> Legal <input type="checkbox"/> Personal <input type="checkbox"/> Other (Specify): _____
<b>Expiration Date</b>	This authorization will expire one year from the date of signature or on _____
<b>Revocation</b>	I understand that I may revoke this authorization at any time by sending a written notice to the health care facility/provider noted above. However, the revocation is not valid if: (1) action was previously taken in reliance on this authorization; or (2) this authorization is obtained as a condition for obtaining insurance coverage; other law provides the insurer with the right to contest a claim under the policy or the policy itself.
<b>Authorization</b>	<p>I hereby authorize the above facility/provider to disclose medical information concerning the above named patient to the party identified in the section entitled "Disclose Information To". I understand that the information to be released may include information regarding mental health, alcohol and drug usage, and HIV-related information. I understand that once the information is disclosed, it may be subject to re-disclosure by the recipient and may no longer be protected. I understand that this authorization is voluntary and that I may refuse to sign this authorization. Unless allowed by law, my refusal to sign will not affect my ability to obtain treatment; receive payment; or eligibility for benefits.</p> <p>_____          Signature of patient/representative                                    Signature Date</p> <p>_____          (Relationship to patient, if signed by representative)                                    (Witness - optional)</p> <p>Please supply proof of authority to act. For minors, proof only required if other than parent.</p>
<b>Disposition</b>	For office use only: Date Sent: _____ Sent by: _____ Chart # _____