# AUTHORIZATION TO DISCLOSE PERSONAL HEALTH INFORMATION

**I hereby authorize the use or disclosure of information from the medical record of:**

Patient Name _____ Medical Record # _____

Date of Birth _____ Social Security #x _____(optional)

**I authorize the following individual or organization to disclose the above named individual's health information:**

_____ **Address:** _____

**This information may be DISCLOSED TO and used by the following individual or organization:**

x_____ Address:x_____

**For the purpose of**:_____

**Please release the following: {Note: list not required by HIPAA}**

___Entire Record

**or:**
- ___Problem List
- ___Progress Notes
- ___History/Physical Exam
- ___Medication List
- ___Immunization Record
- ___List of Allergies
- ___X-Ray/Imaging Reports-from (date)_____ to (date)_____
- ___X-Ray Films
- ___Laboratory Results-from (date)_____to (date)_____
- ___EKG Reports
- ___Genetic Testing Information
- ___Other Diagnostic Reports (Specify)_____
- ___Other (Specify)_____

x-I understand that the information in my health record may include information relating to sexually transmitted disease, acquired immunodeficiency syndrome (AIDS), or human immunodeficiency virus (HIV). It may also include information about behavioral or mental health services, and treatment for alcohol and drug abuse.

___**Yes**, I consent to the release of this information. ___ **No**, I do not consent to the release of this information.

I understand that the information released is for the specific purpose stated above. Any other use of this information without the written consent of the patient is prohibited.

I understand that I have a right to revoke this authorization at any time. I understand that if I revoke this authorization I must do so in writing and present my written revocation to the individual or organization releasing information. I understand that the revocation will not apply to information already released in response to this authorization. I understand that the revocation will not apply to my insurance company when the law provides my insurer with the right to contest a claim under my policy. Unless otherwise revoked, this authorization expires upon completion of this request or upon the following date: 6 **months from the date of the request.**

I understand that authorizing the disclosure of this health information is voluntary. I can refuse to sign this authorization. I need not sign this form in order to ensure treatment. I understand that I may inspect or copy the information to be used or disclosed, as provided in CFR 164.524. I understand that any disclosure of information carries with it the potential for an unauthorized re-disclosure and the information may not be protected by federal confidentiality rules. If I have questions about disclosure of my health information, I can contact **The Center for Orthopedic Surgery** *(insert privacy officer or other office or individuals name or contact information.)*

**x**_____ **x**_____

Signature of Patient or Legal Representative — Date

_____ **x**_____

Relationship to Patient (If Legal Representative) — Witness

***COMPLETE ONLY IF INFORMATION IS TO BE RELEASED DIRECTLY TO PATIENT:***

I understand that my medical record may contain reports, test results, and notes that only a physician can interpret. I understand and have been advised that I should contact my physician regarding the entries made in my medical record to prevent my misunderstanding of the information contained in these entries. I will not hold _____ liable for any misinterpretation of the information in my medical record as a result of not consulting my physician for the correct interpretation. **By Federal Law(HIPAA)regulations we are Not Allowed to release other doctor's records to you.**

_____ _____

Signature of Patient or Legal Representative — Date

_____ _____

Relationship to Patient (If Legal Representative) — Witness

**By Federal Law/HIPAA regulations we are Not Allowed to release other Doctor's records to you**