The ORTHOPAEDIC CENTER

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AUTHORIZATION TO USE OR SHARE PROTECTED HEALTH INFORMATION (PHI)

I. INDIVIDUAL INFORMATION (FOR PERSON WHOSE INFORMATION WILL BE SHARED)

Name	Date of Birth	Account #
Address	City	
Area Code & Telephone Number	State	Zip

II. SCOPE & PURPOSE FOR SHARING INFORMATION

I understand protected health information is information that identifies me. I hereby authorize **The Orthopaedic Center** to share my protected health information as set forth below, for reasons in addition to those already permitted by law.

A. Person/Organization Receiving Information and Purpose for Sharing

Person/Organization Authorized to Receive My Information (Name, Address, Phone & Fax)	Relationship	Purpose For Sharing Information

B. Information to be shared:

☐ Psychotherapy Notes (if checking this box, no other boxes may be checked)
☐ Entire Medical Record ☐ Mental Health Records ☐ Substance Abuse Records
☐ MRI/X-ray
☐ Billing Information for _____
☐ Medical information compiled between _____ and _____
☐ Other: _____

I understand that by voluntarily signing this authorization:

- I authorize the use or disclosure of my PHI as described above for the purpose(s) listed.
- I have the right to withdraw permission for the release of my information. If I sign this authorization to use or disclose information, I can revoke this authorization at any time. The revocation must be made in writing to The Orthopaedic Center and will not affect information that has already been used or disclosed.
- I have the right to receive a copy of this authorization.
- I understand that signing this authorization will not affect my eligibility for benefits, treatment, enrollment, or payment of claims.
- My medical information may indicate that I have a communicable and/or non-communicable disease which may include, but is not limited to diseases such as hepatitis, syphilis, gonorrhea, or HIV or AIDS and/or may indicate that I have or have been treated for psychological or psychiatric conditions or substance abuse.
- I understand I may change this authorization at any time by writing to The Orthopaedic Center.
- I understand that I cannot restrict information that may have already been shared based on this authorization.
- Information used or disclosed pursuant to the authorization may be subject to redisclosure by the recipient and no longer be protected by the Privacy Regulation.

Unless revoked or otherwise indicated, this authorization's automatic expiration date will be one year from the date of my signature or upon the occurrence of the following event: _____

Signature of Patient or Legal Representative	Date
Description of Legal Representative's Authority	Expiration Date (if longer than one year from date of signature or no event is indicated)

Do not write below this line: for completion by The Orthopaedic Center only.

Accepted by: _____ Date: _____

Information was provided to the individual on the following date _____