AUTHORIZATION TO USE OR SHARE PROTECTED HEALTH INFORMATION (PHI)

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

Patient Name: _____ DOB_____ Account #_____

Address:_____City:_____State:____ Zip: _____

Phone Number: (_____)_____-_____

II. SCOPE & PURPOSE FOR SHARING INFORMATION - *Section II Parts A & B must be completed.*

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

Name: _____Address:_____

Phone: (_____) _____ - _____ Fax: (_____) _____ - _____ City: _____ State: ____ Zip: _____

Relationship: _____ Reason for Sharing: _____

B. Information to be Shared (Check all that apply)

- ☐ Entire Medical Record ☐ Mental Health Records ☐ Substance Abuse Records
- ☐ MRI / X-Ray / CT Scan
- ☐ Billing Information for _____
- ☐ Medical Information Compiled Between _____ and _____
- ☐ Psychotherapy Notes (if checking this box, no other boxes may be checked)
- ☐ 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.
- If I sign this Authorization to Use or Share Protected Health Information (PHI), I have the right to 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 a right to receive a copy of this Authorization to Use or Share Protected Health Information (PHI).
- I understand that signing this Authorization to Use or Share Protected Health Information (PHI) 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: hepatitis, syphilis, gonorrhea, HIV or AIDS and/or may indicate that I am being or have been treated for psychological or psychiatric conditions or substance abuse.
- I understand I may change this Authorization to Use or Share Protected Health Information (PHI) 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 to Use or Share Protected Health Information (PHI) may be subject to re-disclosure by the recipient and no longer be protected by the Privacy Regulation.

Unless revoked or otherwise indicated, this Authorization to Use or Share Protected Health Information (PHI) will expire one year from the date of signature or upon occurrence of the following event: _____

_____ _____

Signature of Patient or Legal Representative **Date**

_____ _____

Description of Legal Representative's Authority **Expiration Date (if longer than 1 year from the 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: _____