

AUTHORIZATION OF USE AND DISCLOSURE OF PROTECTED HEALTH INFORMATION

DATE: _____ PATIENT NAME: _____

DOB: _____ CHART NO.: _____

1. INFORMATION TO BE USED OR DISCLOSED

The information covered by this authorization is specifically limited to:

2. PERSONS AUTHORIZED TO DISCLOSE INFORMATION

Information listed above will be disclosed by:

Name of person or organization Phone No.

Address of organization Fax No.

3. PERSONS TO WHOM INFORMATION MAY BE DISCLOSED

Information described above may be disclosed to:

Name of person or organization Phone No.

Address of organization Fax No.

4. EXPIRATION DATE OF AUTHORIZATION

This authorization is effective through ___/___/___ unless revoked or terminated by the patient or the patient's personal representative. If not dated this will expire in 90 days.

RIGHT TO TERMINATE OR REVOKE AUTHORIZATION

You may revoke or terminate this authorization by submitting a written revocation to Brookwood Orthopedics. You should contact the Medical Records Department to terminate this authorization.

POTENTIAL FOR RE-DISCLOSURE

Information that is disclosed under this authorization may be disclosed again by the person or organization to which it is sent. The privacy of this information may not be protected under the federal privacy regulations.

SIGNATURE

Name of patient (print or type)

Signature of patient Date

Signature of patient representative (if applicable)

OFFICE USE ONLY

Patient received _____ Mailed on _____ Fax to _____
