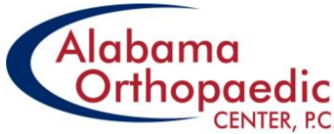

3525 Independence Drive - Birmingham, Alabama 35209 - (205) 802-6700 - fax (205) 802-6701 - www.alabamaorthocenter.com

AUTHORIZATION FOR USE AND DISCLOSURE OF PROTECTED HEALTH INFORMATION

Patient Name: ______________________________ **DOB:** ________________________
Address: ______________________________ **SSN:** ________________________
______________________________ **Phone:** ________________________
______________________________ **Fax:** ________________________

Alabama Orthopaedic Physician: ____

Information to be used or disclosed:

____ Entire Medical Record
____ Demographics
____ Office Notes
____ Diagnostic Reports
____ Operative/Hospital Reports

____ Other: Please specify
____
____

Purpose of this disclosure: ____

Please specify any information **NOT** to be disclosed: ____

Name or specific identification of the person(s), or class of persons to whom we may release the information:

____

How would you like us to send your information?
_____ Pick up in Office
_____ Mail: Please List Address
____
____
_____ Fax: Please List Fax Number
____

Expiration date or expiration event of the request (unless otherwise specified, request will expire six (6) months from the signature date below): ____

By signing the below, you hereby authorize us to use or disclose information about yourself (or another person for whom you have the authority to sign) that is protected under federal law, for the sole purpose and time period described above.

This information about you is protected under federal law and you have the right to revoke this authorization in writing. Please be advised, however that any revocation will be effective only to the extent that we have not already taken action in reliance on your authorization. Please recognize that the protected health information used or disclosed pursuant to this authorization may be subject to re-disclosure by the recipient of the disclosure and may no longer be protected under federal law.

You may refuse to sign this authorization. Subject to certain exceptions, you may have the right to inspect and copy the protected health information.

____ __________________________
Patient Signature or Personal Representative Date

As a personal representative, I have authority to act for the individual because I am:
____