Orthopaedic Surgical Associates

Authorization for Use/Release of Health Information

Name:_____ Phone:_____

Date of Birth:_____/_____/_____ S.S.#_____/_____/_____

I hereby authorize Orthopaedic Surgical Associates to:

_____ Release Information To: _____ Obtain Information From:

Person/Agency:_____

Address:_____

City, State, Zip:_____

Phone #:_____ Fax #:_____

DATES OF TREATMENT	Dates:_____

PURPOSE OF RELEASE	INFORMATION REQUESTED
(please initial all that apply)	*(please circle Y or N for each line)*
_____Second Opinion with: _____	Y N Verbal Information Only
_____Continued Treatment	Y N Progress Notes
_____Personal Use	Y N Lab Reports
_____Legal Use	Y N X-Ray Report Only
_____Employment	
_____Other: (please specify) _____	_____ Other (please specify):_____ _____

_____ I understand that this information may include any history of acquired immunodeficiency syndrome (AIDS); sexually transmitted diseases; human immunodeficiency virus (HIV) infection; behavioral health service/psychiatric care; treatment for alcohol and/or drug abuse; or similar conditions. This does not indicate that I have these conditions but allows the release of the records without review.

_____ I have been provided a copy of the Orthopaedic Surgical Associates Notice of Privacy Practices and any charges that may be associated with this authorization. I have discussed any concerns I may have about the use, release, and disclosure of my health information disclosed under this authorization. I release Orthopaedic Surgical Associates from any legal liability that may arise from this authorization.

_____ The patient or their representative may revoke this authorization by notifying in writing Orthopaedic Surgical Associates designated Privacy Officer. Federal Law states that treatment, payment, enrollment, or eligibility for benefits may not be conditioned on obtaining this authorization if such conditioning is prohibited by the Privacy Rule. Federal Law also requires a statement that there is the potential for the protected health information released under this authorization may be subject to redisclosure by the recipient.

Signature of Patient or Representative_____ Date_____/_____/_____

Relationship to patient_____ Witness_____

Drivers License number or other I.D._____

This authorization shall be in effect for **90 days** following the date of signature.

Date of Request:_____ **Request Taken By:**_____ **Needed By:**_____

P/U:_____ **Fax:**_____ **Mail:**_____ **E-mail:**_____

Records Sent On:_____ **Sent By:**_____

1275 Sadler Way Suite 101
Fairbanks AK, 99701
Phone: (907)374-4463
Fax (907) 374-7072