AUTHORIZATION TO USE OR DISCLOSE PROTECTED HEALTH INFORMATION

(Please Fill Out Completely)

I hereby authorize Perimeter Orthopaedics to use or disclose my health information as follows:

Patient Name: ___________________________________ Date of Birth: _______________
Address (Street, City/State, Zip): ____
Phone: _________________________ SSN (last 4 digits): ________________________________
Date(s) of Service: ____

Information To Be Released – Covering the Periods of Health Care

From (date) ___________________________ To (date) __________________________

Please check type of information to be released:

☐ Complete health record	☐ Office Notes Only	☐ Physical Therapy Notes
☐ Laboratory test results	☐ Itemized Billing Statement	☐ X-ray films / images (fee may apply)
☐ Other (specify)	☐ Surgical Notes	

Purpose of Request:

☐ Treatment or consultation	☐ At the request of the patient	☐ Billing or claims payment
☐ Other (specify)		

RECIPIENT INFORMATION

I am requesting that the records identified above be handled in the following manner:

☐ Mail To Address Listed Above ☐ I will pick-up ☐ Fax Number/Attn: ______________
☐ A Representative will pick-up on my behalf (list name of Representative) ___________________
Mail information to : ☐ Clinic ☐ Dr. Office ☐ Self
Name/Address/Phone: ____
____

This request is for the purpose of: ____

I understand that I have the right to revoke this authorization at any time. I understand that my revocation must be in writing and addressed to the privacy officer of the above named facility authorized to make the disclosure. I understand that the revocation does not apply to information that has already been released in response to this authorization. Unless otherwise revoked this authorization will expire in six months.

I understand that any disclosure of information may be subject to re-disclosure by the recipient and may no longer be protected by Federal or State law. I understand that authorizing is voluntary. I understand that if I have any questions about disclosure of my health information, I may contact the prevacy officer at the facility listed above that is authorized to disclose this information and request a copy of this authorization.

I understand that the information in my health record may include information pertaining to treatment of drug and alcohol abuse, mental health, acquired immunodeficiency syndrome (AIDS), or human immunodeficiency virus (HIV), sexually transmitted diseases, tuberculosis information or genetics. THIS INFORMATION WILL ALSO BE RELEASED UNLESS YOU INDICATE: ______ DO NOT RELEASE (Indicate with a check mark).

____ ____________________
Signature of Patient or Authorized Representative Date