ORTHOPAEDIC
SPORTS SPECIALISTS

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RELEASE FOR USE OR DISCLOSURE

OF PROTECTED HEALTH INFORMATION

I authorize the release of my health information to the above underlined listed medical practice/institution:

TO: _____

Name of Medical Practice/Institution

ADDRESS: _____

PATIENT NAME AND DATE OF BIRTH: _____

ADDRESS: _____

Description of health information to be used or disclosed:

_____

_____

I understand that this health information may include HIV-related information and/or information relating to diagnosis or treatment of psychiatric disabilities and/or substance abuse and that by signing this form, I am authorizing such information to be disclosed.

Effect of refusal to sign Release:

I understand that my refusal to sign this release will not jeopardize my right to obtain present of future treatment for psychiatric disabilities except where disclosure of the information is necessary for the treatment.

Expiration Date of Release:

This release is effective through ____/____/____ unless revoked or terminated by the patient or the patient's personal representative.

Right to Terminate or Revoke Release:

You may revoke or terminate this release by submitting a written request.

Potential for Re-Disclosure:

Information that is disclosed under this release 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.

I understand that I have the right to receive a copy of this release.

_____

Name of Patient (Print or Type)

_____ _____

Signature of Patient Date:

_____ _____

Signature of Patient Representative Relationship to Patient