ANNISTON ORTHOPEDICS ASSOCIATES, PA

AUTHORIZATION FOR USE AND DISCLOSURE OF PROTECTED HEALTH INFORMATION

Patient Name:____ Date of Birth:____________________

Patient
Address:____
__

SSN:____________________________

Information to be used or disclosed (must be identifies in a specific and meaningful fashion); and purpose of the use and
disclosure:____
____
____

Information that may not be used or disclosed:
____
____
____

Whom may we release this information to? Spouse Parent Sibling Son Daughter Partner Other
Name(s):____
____

The name of other specific identification of the person(s), or class of persons, authorized to make the requested use of the disclosure: Anniston Orthopedics Associates, P.A 731 Leighton Ave, Ste 300 Anniston, AL 36207

The name or other specific identification of the person(s), or class of persons, to whom Anniston Orthopedics may make the requested disclosure:____

<u>Are we permitted to leave a message/voicemail on an answering machine or cell phone?</u> YES or NO

Cell/Home #:_________________________________Expiration date of disclosure: ____________________

By signing below, you 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. You may refuse to sign this authorization. Subject to certain exceptions, you have the right to inspect and copy the protected health information. You have the right to revoke this authorization in writing. Please be advised, any revocation will be effective only to the extent we have not already taken action in reliance on your authorization. By signing below, you recognize that the protected health information used or disclosed pursuant to this authorization may be subject to re-disclosure by the recipient of this disclosure and may no longer be protected under Federal Law. We will not condition treatment based on your authorization. You may refuse to sign the authorization.

____ Date:___________________

Patient/Representative Signature

As personal representative, I have authority to act for the individual because I am: POWER OF ATTORNEY OR GUARDIAN Name:____