

Orthopedic Group, Inc.

Authorization for Use and Disclosure of Protected Health Information

Form must be completed in its entirety prior to the release of Protected Health Information (PHI)

Patient's Full Name: _____ Date of Birth: ____/____/____

I hereby authorize Orthopedic Group, Inc., its physicians, providers and staff to use and/or disclose the Protected Health Information described below to (Entity to whom information is being released):

for the purpose(s) of (specify the reason that this information is being released):

- communications to another health care provider assisting with interpreting*
 payment of OGI medical charges to communicate to /with a family member
 forwarding to a third party
 other: _____

Information to be released:

- all of my personal health information, excluding the following:

 only the following personal health information

 only personal health information related to today's visit
 personal health information related to today's visit and all future visits
 The following specific dates: _____

* I have arranged for my own interpreter and am comfortable with their ability to effectively and accurately interpret for me.

1. I understand that I may inspect or obtain a copy of the protected health information described by this authorization. The fee for reproducing records, as allowed by state regulation, consists of a retrieval fee of \$15.00 and \$.25 per page.
2. I understand that Orthopedic Group, Inc. will not condition treatment, payment or (if applicable) enrollment in the health plan or eligibility for benefits on my providing authorization for the requested use or disclosure AND THAT I MAY REFUSE TO SIGN THIS AUTHORIZATION.
3. I understand that I may revoke this authorization in writing at any time by delivering such written revocation to the Privacy Officer of Orthopedic Group, Inc. I also understand that such revocation will not be effective as to the disclosure of records whose release I have previously authorized, or where other action has been taken in reliance on an authorization I have signed.
4. I understand that information used or disclosed pursuant to this authorization could be subject to re-disclosure by the recipient and, if so, may not be subject to federal or state law protecting its confidentiality.

EXPIRATION DATE: This authorization will expire on ____/____/____ (date no later than one year from now)
(If no date is stated, this authorization expires six months from the date it was signed.)

COPY PROVIDED: Orthopedic Group, Inc. shall provide a copy of this signed authorization to you upon your request. This information will be disclosed to you from records whose confidentiality is protected by federal law. Federal regulations prohibit you from making any further disclosure of it without the specific written consent of the person to whom it pertains.

State law requires an individual or the individual's authorized legal representative to give specific consent for the release of protected health information related to certain disease conditions. By my signature below, I authorize release of the following medical information that may be held by Orthopedic Group: general protected health information, information pertaining to my HIV status and records of care and treatment for HIV/AIDS, records of mental health care and treatment, records of substance abuse care and treatment and records of diagnosis, care and treatment of sexually transmitted disease.

_____/_____/_____
Date Signature of Patient or Authorized Representative Authority or Relationship to Patient
(Only if signature is not that of the patient)