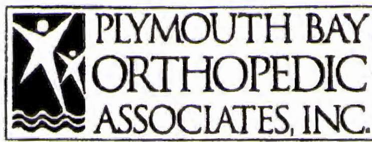


## AUTHORIZATION TO USE OR DISCLOSE PROTECTED HEALTH INFORMATION

1. I hereby authorize Plymouth Bay Orthopedic Associates, Inc. to use or disclose the following health information from the medical records of the patient listed below. 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.

2. Patient Name:________________________________________ Date of Birth:______________
FIRST MI LAST

Address:________________________________________________________________
STREET CITY S TATE ZIP

Phone Number:___________________________________________________________

3. **Information to be disclosed to:**__________________________________________
FULL NAME

Address:________________________________________________________________

4. **Disclose the following information for treatment dates:**______________ to ______________

| | | |
|---|---|---|
| __Complete Records | __Consult | __Physical Therapy |
| __Discharge Summary | __X-Ray | __Emergency Reports |
| __History & Physical | __Laboratory | __Other (specify)______________ |
| __Outpatient Reports | __Pathology | ______________________ |

5. The above information is **disclosed for the following purposes**:

__Medical Care __Legal __Insurance __Personal __Other______________

6. I understand that I may revoke this authorization at any time by requesting such of the above-referenced hospital/physician/facility in writing, unless action has already been taken in reliance upon it, or during a contestability period applicable under law. This authorization expires after ninety ( 90 ) days from the date I signed it unless otherwise specified.

______________________________ ______________________________
7. Signature of Patient or Legal Representative 8. Date

______________________________ ______________________________
9. Printed Name of Patient or Patient's Representative 10. Relationship to Patient or Authority to act for Patient ( attach documentation )

I understand that my record may contain information in reference to treatment for substance abuse and/or alcohol abuse, psychiatric treatment, sexually transmitted diseases, social services notes, or other sensitive information such as HIV status. I agree to it's release unless otherwise specified ( please explain ).

______________________________ ______________________________
12. Signature of Patient or Legal Representative 13. Date

______________________________ ______________________________
14. Printed Name of Patient or Legal Representative 15. Relationship to Patient or Authority to act for Patient ( attach documentation )