PLYMOUTH BAY ORTHOPEDIC ASSOCIATES, INC.

# 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 STATE ZIP

Phone Number: _____

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

Address: _____
STREET CITY STATE ZIP

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

- ☐ Complete Records
- ☐ Discharge Summary
- ☐ History & Physical
- ☐ Outpatient Records
- ☐ Consult
- ☐ X-Ray
- ☐ Laboratory
- ☐ Pathology
- ☐ Physical Therapy
- ☐ Emergency Reports
- ☐ Other (Specify) _____

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

☐ Medical Care ☐ Legal ☐ Insurance ☐ Personal ☐ Other _____

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 LEGAL REPRESENTATIVE

**10.** RELATIONSHIP TO PATIENT OR AUTHORITY TO ACT FOR PATIENT (ATTACH DOCUMENTATION)

**11.** 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)