St.Charles Orthopedics

PATIENT AUTHORIZATION FOR USE AND DISCLOSURE OF PROTECTED HEALTH INFORMATION

Patient Name:_____ Date of birth_____

Doctor seen:_____

By signing this authorization, I authorize St. Charles Orthopedics to use and/or disclose certain protected health information (PHI) about me. Please send information to:

Name_____

Address_____.

This authorization permits St. Charles Orthopedics to use and/or disclose the following individually identifiable health information about me (specifically describe the information to be used or disclosed, such as date(s) of services, type of services, level of detail to be released, origin of information, etc.):

_____

_____.

The information will be used or disclosed for the following purpose: _____

_____.

If requested by the patient, purpose may be listed as "at the request of the individual."

The purpose(s) is/are provided so that I can make an informed decision whether to allow release of the information. This authorization will expire on _____ {Expiration Date or Defined Event}.

The Practice will ___ will not XX receive payment or other remuneration from a third party in exchange for

using or disclosing the PHI.

I do not have to sign this authorization in order to receive treatment from St. Charles Orthopedics. In fact, I have the right to refuse to sign this authorization. When my information is used or disclosed pursuant to this authorization, it may be subject to redisclosure by the recipient and may no longer be protected by the federal HIPAA Privacy Rule. I have the right to revoke this authorization in writing except to the extent that the practice has acted in reliance upon this authorization. My written revocation must be submitted to George Gmytrasiewicz, the Privacy Officer, at:

6 Technology Drive, Suite 100
Address
East Setauket NY
11733

Signed by:_____

Signature of Patient or Legal Guardian:_____

Relationship to Patient:_____

Print Patient's Name:_____ Date:_____

_____

rev. 04/13

_____

Print Name of Legal Guardian (if applicable)_____

PATIENT/GUARDIAN TO BE PROVIDED WITH A SIGNED COPY OF AUTHORIZATION