ADAM MADSEN, D.O.
ORTHOPEDIC SURGERY

Authorization to Use and Disclose Protected Health Information

Authorization to release the protected health information of:		
Patient Name:		
Current Address:		
Social Security #:	Phone #:	Date of Birth:
This authorization is to release the protected health information to:		
Name:		
Address:		
This authorization is to release the protected health information from:		
Facility/Provider Name:		
Address:		
The purpose of this disclosure is:		
Dates of service:		

Release the following information:

o Discharge summary	o Cardiology report
o History & Physical	o Psychiatric report
o Consultations	o Treatment plan
o Operative report	o Alcohol/Drug Treatment record
o Progress Notes	o Itemized Billing Statement
o Emergency report	o X Rays
o Radiology report	o X Ray copies ($5.00 each)
o Lab report	o Other records as specified

Term: This Authorization will remain in effect:

- o From the date of this Authorization until:
- o Until the following evert occurs:

Unless otherwise noted above, this authorization will remain in effect 180 days from the date signed.

I understand that:

- ✓ once *"this facility"* discloses my health information by my request, it cannot guarantee the Recipient will not disclose my health information to a third party. The third party may not be required to abide by this Authorization or applicable federal and state law governing the use and disclosure of my health information.
- ✓ I may make a request in writing at any time to *"this facility"* to inspect and/or obtain a copy of my health information maintained at this facility as provided in the Federal Privacy Rule 45 CFR 164.524.
- ✓ my records are protected and cannot be disclosed without my written permission. *Alcohol/drug treatment records are protected by Federal Rule 42 CFR, part 2.
- ✓ this Authorization will remain in effect until the Authorization expires or I provide a written notice of revocation to the Health Information Services Medical Record Department.

To be used if facility requests this authorization:

I understand that:

- ✓ I may refuse to sign or may revoke this Authorization at any time for any reason and that such refusal or revocation will not affect the commencement, continuation, or quality of *"this facility's"* treatment of me, enrollment in the health plan, or eligibility for benefits.
- ✓ I may make a request in writing at any time to *"this facility"* to inspect and/or obtain a copy of the protected health information maintained at this facility to be used or disclosed as provided in the Federal Privacy Rule 45 CFR 164.524.

Signature of Patient or Legal Representative	Date
Signature of Witness	

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