Authorization for Disclosure of Protected Health Information

Patient Name: _____ **Date of Birth:** _____

Address: _____

Phone: _____

Proliance may disclose health information from:

☒ A specific location: Everett Bone and Joint

☐ All of Proliance

Proliance may disclose the following health information: (Please select all that apply)

☐ Current medical records information (clinic notes, radiology reports, MRI reports, operative reports, etc within the last 12 months)

☐ All medical records information (clinic notes, radiology reports, MRI reports, operative reports, etc)

☐ Health care information in my medical record related to the following treatment/condition: _____

☐ Health care information in my medical record for the date(s): _____

☐ X-ray images

☐ MRI images

☐ Billing information

Proliance may disclose health care information regarding testing, diagnosis, and treatment for the following:

☐ HIV (AIDs virus)

☐ Sexually transmitted disease

☐ Psychiatric disorders/mental health

☐ Drug and/or alcohol use

Proliance may disclosure this health care information to:

Name (or title) and organization: _____

Address: _____

City: _____ State: _____ ZIP: _____

Phone: _____ Fax: _____ Email: _____

Preferred method of delivery: ☐ Print ☐ Fax ☐ Secure Email ☐Electronic Media (CD/Flash Drive)

Reasons for this authorization:

☒ At my request

☐ Other: _____

This authorization expires: (This authorization will expire in ninety (90) days after date signed unless the below is specified)

☐ On date: _____

☐ When the following event occurs: _____

My Rights – I understand that I do not have to sign this Authorization in order to get health care treatment or benefits. I must sign this Authorization to release my health care information to a third party, including another medical provider. I understand that I may revoke this Authorization by completing a Revocation of Authorization to Release Health Information, which is available in my provider's office, or by writing a letter to my provider. If I revoke my Authorization, it would not affect any actions previously taken by Proliance Surgeons, Inc., P.S. based upon this Authorization. I may not be able to revoke this Authorization if its purpose was to obtain insurance. I also understand that once health care information is disclosed, the person or organization that receives it may re-disclose it and that privacy laws may no longer be available to protect it.

_____ _____

Patient or legally authorized individual signature Date

_____ _____

Printed name if signed on behalf of patient Relationship (parent, personal representative, etc)