



AUTHORIZATION TO USE AND/OR DISCLOSE HEALTH INFORMATION

Read entire document before signing

This authorization gives Blair Orthopedics permission to use and/or disclose protected health information about you.

Right not to sign. You may refuse to sign this authorization. Refusal to sign this authorization will not affect your ability to obtain treatment by Blair Orthopedics, except in the case of health care that is solely for the purpose of creating health care information for disclosure to a third party (for example, a pre-employment physical) [or research-related care].

Right to revoke. You may revoke this authorization at any time except to the extent that we have relied on the authorization or if the authorization is to permit disclosure of PHI to an insurance company, as a condition of obtaining coverage, to the extent that other law allows the insurer to contest claims or coverage. To revoke this authorization, you must submit a written revocation to our privacy officer at the following address:

Blair Orthopedics
Attention: Privacy Officer
3000 Fairway Drive
Altoona, PA 16602

Re-disclosure. Health information disclosed pursuant to this authorization may be subject to re-disclosure because it is no longer protected by the federal privacy rule or another privacy law.

Authorized uses and disclosures

Print all information except signature.

1. Patient Name: \_\_\_\_\_ Date of Birth: \_\_\_\_\_

2. Covered Health Information – Describe the covered Protected Health Information (PHI) in a specific and meaningful fashion:

Three horizontal lines for describing covered health information.

3. Identity of user/discloser – Provide the name or other specific identification of the person(s) or class of persons authorized to disclose the covered information:

Blair Orthopedics

Authorized action(s) \_\_\_ uses \_\_\_ disclosures (check one or both boxes as applicable).

4. Identity of Recipient – Provide the name or other specified identification of the person(s) or class of person to whom the covered entity may disclose the covered information: \*

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\*Not necessary if only uses are authorized.

5. Each purpose of the authorized uses and disclosures: \*\*

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\*\* “At request of individual” is sufficient for uses and disclosures initiated by the patient.

6. Expiration of authorization – “X” a selection or provide another date or event that relates to the patient or the purpose of the use and/or disclosure:

\_\_\_ 1 year from date of signature below

\_\_\_ 6 months from date of signature below

\_\_\_ Other (enter date or event) \_\_\_\_\_

**I have read and understand this authorization, and authorize the disclosure of health information about the named patient as described in this authorization.**

\_\_\_\_\_  
Signature of patient (or personal representative)

\_\_\_\_\_  
Date

Personal Representative Information (if applicable):

\_\_\_\_\_  
Name of personal representative

\_\_\_\_\_  
Relationship to patient (or other authority)