

ROWE ORTHOPAEDIC CENTER

Authorization for the Use or Disclosure of Medical Records
(Protected Health Information)

I, _____ hereby authorize the use or disclosure of my Medical Information (PHI) as described below.

Description of Medical Information (PHI) to be used or disclosed.

- Physician Notes Operative Reports Complete Record Lab Reports
 Pathology Reports Correspondence Radiology Reports
 Other (please list in detail) _____

This release also specifically allows the release of the following information unless initialed by patient:

- _____ Records of testing, care, reporting, or research pertaining to HIV or related diseases.
 _____ Drug and/or Alcohol dependency/abuse.

I further authorize the following person(s) may make the request for use or disclosure of my Medical Information (PHI) on my behalf:

- Myself Spouse _____ (name) Parent(s) _____ (name)
 Children _____ (name) Other _____ (name/relationship)

I authorize my Medical Information (PHI) to be released/disclosed to:

Name: _____ Fax: () _____ - _____
Address: _____
City: _____ State: _____ Zip Code: _____

Purpose for Release/Disclosure of information:

- Ongoing Medical Care At My Request Other _____

Authorization expires 1 year from date of signature unless otherwise specified: _____

By signing this authorization, I acknowledge that I have read and understand this Authorization and I authorized the use/disclosure of my Medical Information (PHI) in accordance with the terms of this Authorization by Paragon Health P.C. dba Rowe Orthopaedic Center.

I understand that I may revoke this authorization at any time, except to the extent that action has been taken on it. I further authorize that a photocopy of this release may be used in place of the original.

Signature _____ Relationship _____ Date ____/____/____
(patient/guardian)
Birthdate _____ SS# _____ - _____ - _____
Signature _____ Date ____/____/____
(witness)