

**AUTHORIZATION FOR THE USE OR DISCLOSURE OF
PROTECTED HEALTH INFORMATION and
ACKNOWLEDGEMENT OF RECEIPT OF NOTICE**

As required by the Health Insurance Portability and Accountability Act of 1996, Orthopaedics, P.C. may not use or disclose your health information except as provided in our Notice of Privacy Practices without your authorization. Your signature on this form indicates that you are giving permission for the uses and disclosures of protected health information as described in the above Notice.

I, _____ (print name) hereby authorize the use and/or disclosure for the purpose of carrying out treatment, payment or health care operations.

I understand that information disclosed pursuant to this authorization may be re-disclosed to additional parties and no longer protected.

I understand that I may revoke this authorization at any time by giving written notice to Orthopaedics, P.C. I further understand that any such revocation does not apply to the extent persons authorized to use or disclose my health information have already acted in reliance on this authorization.

I further understand that my ability to obtain treatment, my eligibility for benefits, etc. will not depend in any way on whether I sign this authorization or not.

I understand that I have a right to inspect and obtain a copy of any information disclosed pursuant to this authorization.

I acknowledge that a copy of Orthopaedics, P.C. Notice of Privacy Practices was made available to me and/or I received a copy and understand how the practice may use and disclose my confidential information. I further understand that the physician has reserved a right to change his privacy practices that are described in the Notice and a copy will be made available to me of the revision.

Signed: _____ Date: _____

If not signed by the patient, please indicate relationship: _____

Signed form received by: _____

Reason Acknowledgment refused: _____
