CAPSTONE
ORTHOPEDICS & SPORTS MEDICINE

# AUTHORIZATION TO USE OR DISCLOSE PROTECTED HEALTH INFORMATION

Patient Name _____
Date of Birth _____/_____/_____
Social Security Number _____-_____-_____
Address: _____
_____
_____
Telephone Number (____) _____-_____

I hereby authorize the use or disclosure of my individually identifiable health information. I understand that this authorization is voluntary. I understand that once information is disclosed, it may be re-disclosed by the recipient and the information may not be protected by federal privacy laws or regulations.

| **Person(s) or Facility to *Send* Information** | **Person(s) or Facility to *Receive* Information** |
|---|---|
| Name _____ | Name _____ |
| Address _____ | Address _____ |
| City_____ ST _____ Zip _____ | City _____ ST _____ Zip_____ |
| Phone_____ Fax_____ | Phone_____ Fax_____ |

This Information will be used for:

- ☐ My personal records
- ☐ Sharing with other health care providers
- ☐ Other (please describe):

**Information to Be Disclosed**

| DOCUMENTS | CHECK IF REQUESTED | TREATMENT DATE(S) AND/OR SPECIFIC BODY PART |
|---|---|---|
| Demographics | ☐ | |
| Office Notes | ☐ | |
| Hospital/ER Records | ☐ | |
| Surgery/Op Notes | ☐ | |
| Lab/Path/Micro | ☐ | |
| Diagnostics/Radiology | ☐ | |
| Entire Inside Record | ☐ | |
| Other: | ☐ | |

I understand that I may revoke this authorization at any time by notifying the providing organization in writing, but if I do, it will not have any affect on any actions taken before the revocation was received. Unless revoked, this authorization expires 1 year from the date signed below unless otherwise requested here:

A faxed photocopy of this authorization shall be considered valid. I give permission for this information to be faxed if necessary.

**I HEREBY AUTHORIZE THE RELEASE OF MY MEDICAL RECORDS AS PROVIDED ABOVE.**

_____ _____
Signature of Patient or Patient Representative Date

_____ _____
Printed Name of Patient or Patient Representative Relationship to Patient if Signed by Representative

**FOR CAPSTONE ORTHOPEDICS & SPORTS MEDICINE USE:**

Received by: _____ (Employee / Dept) MR# _____