

Use or Disclosure Authorization

I, _____, hereby authorize **Resurgens Orthopaedics** to use or disclose the following protected health information:

(Describe the information to be used or disclose in specific terms, including descriptions such as date of service, type of service)

The protected health information may be disclosed to:

(Please check and provide the name or specific entities to whom your protected health information may be disclosed.)

_____ **School:** _____

_____ **Employer:** _____

_____ **Athletic coaches:** _____

_____ **Disability company:** _____

_____ **Disability Loan Forms: Lender** _____

_____ **Opposing attorney:** _____

_____ **Defending attorney:** _____

_____ **Spouse** _____ **Other: (please list specific names or entities)**

This protected health information is being used or disclosed for the following purposes:

Please check per patient's request or list reason for disclosure.

_____ **Per patient's request**

_____ **Other please list:** _____

This authorization shall be in force and effect until: *(Check one of the following)*

Date _____

The occurrence of the following event:

No expiration.

I understand that, as set forth in the Provider's Privacy Notice, I have the right to revoke this authorization at any time by sending written notification to:

Attention: Privacy Leader/Site Manager

I understand that my written revocation does not effect any protected health information previously released.

I understand that information used or disclosed pursuant to this authorization may be subject to redisclosure by the recipient and may no longer be protected by federal or state law.

I understand that: *(Check one of the following)*

- The Provider will not deny treatment based on whether or not I sign this authorization for disclosure.
- The health care provided by the provider is solely for the purposes of creating protected health information to be disclosed to the person or entity named above. My authorization is a condition of this treatment. I understand that if I do not sign this authorization, then the provider will not provide health care services to me. Example: An attorney requesting an independent medical exam.
- The treatment being provided by the Provider is related to research and that my authorization of disclosures for related research purposes is a condition of this treatment. I understand that if I do not sign this authorization, then the Provider will not provide research related treatment to me.

I understand that, as set forth in the Provider's Privacy Notice, I have the right to inspect or copy the protected health information to be used or disclosed as permitted under federal law (or state law to the extent the state law provides greater access rights.)

I understand that I have the right to refuse to sign this authorization.

Patient or Personal Representative's Signature

Date

Printed Name of Patient or Personal Representative

Relation to the Patient

IDX Entry Date _____
Employee Initials

*Any Additions or Changes need to be completed on a separate form and attached to the original.