

AUTHORIZATION TO USE AND/OR DISCLOSE HEALTH INFORMATION

I, [name of patient] _____, authorize **Fondren Orthopedic Group, LLP** to use and/or disclose my health information as identified below to:

Name of Provider: _____

Address: _____

Phone Number: _____

Fax Number: _____

for the following purpose(s): [describe each purpose; if requested by the patient, you may state "at patient's request"]

By initialing the spaces below, I specifically authorize the use or disclosure of the following health information and/or records, if such information and/or records exist:

_____ All records from _____ (date) to _____ (date)

_____ Initial Exam records

_____ All Office Visit notes

_____ All Hospital records (including nursing records, progress notes, and transcribed notes)

_____ Medical records needed for continuity of care

_____ Laboratory/Pathology reports

_____ Diagnostic images and imaging reports

_____ Emergency and urgent care records

_____ Billing/Financial statements

_____ Psychotherapy notes (Authorization for the use and/or disclosure of psychotherapy notes cannot be combined with any other authorization.)

_____ Drug/alcohol diagnosis, treatment, and/or referral information (By Federal law, you must provide a description of what information is to be released. Federal law prohibits the re-disclosure of such information.) _____

_____ Other _____

(Continued on next page)

Except to the extent that action has already been taken in reliance upon this authorization, I understand that I may revoke this authorization at any time by giving written notice to **Fondren Orthopedic Group, LLP**. Unless revoked earlier, this authorization will expire 180 days from the date of signing or upon [specific date or event]_____.

I understand that I may refuse to sign this authorization and that my refusal to sign will not affect my ability to obtain treatment, payment, enrollment, or eligibility for benefits. I may inspect or copy any information to be used or disclosed under this authorization.

I also understand that, if the person or entity receiving this information is not a health care provider or health plan covered by federal privacy regulations, the information described above may be re-disclosed and no longer protected by these regulations. However, the recipient may be prohibited from disclosing my health information under other applicable state or federal laws and regulations.

I further understand that the person(s) I am authorizing to use or disclose my information may receive compensation (either directly or indirectly) for doing so.

Signature of Individual or Individual's Legal Representative

Date

Print Name or Print Name of Legal Representative

Relationship to Individual

Office Use Only:

Received by

Date

(A copy of this signed form will be provided to the individual and/or the individual's legal representative.)