



**AUTHORIZATION TO DISCLOSE  
HEALTH INFORMATION**  
ALL SECTIONS MUST BE COMPLETE

Patient Name \_\_\_\_\_ SS Number (Optional) \_\_\_\_\_  
Date of Birth \_\_\_\_\_ Address \_\_\_\_\_  
Phone Number \_\_\_\_\_ Date of Service \_\_\_\_\_ Patient Number \_\_\_\_\_

**I authorize the use or disclosure of the above named individual's health information as described below:**

- 1. The Orthopaedic Center (TOC) is authorized to make the disclosure.
- 2. The type and amount of information to be used or disclosed is as follows: (include dates where appropriate)  

<input type="checkbox"/> Consultation Report	<input type="checkbox"/> Lab Report	<input type="checkbox"/> Progress Note
<input type="checkbox"/> Discharge Summary	<input type="checkbox"/> MRI Report	<input type="checkbox"/> Referral Report
<input type="checkbox"/> EMG Report	<input type="checkbox"/> Nurses' Notes	<input type="checkbox"/> Work Status
<input type="checkbox"/> H & P	<input type="checkbox"/> Op Note	<input type="checkbox"/> X-Ray Report
<input type="checkbox"/> Other _____		
- 3. I understand that the information in my health record may include information relating to sexually transmitted diseases, acquired immunodeficiency syndrome (AIDS), or human immunodeficiency virus (HIV). It may also include information about behavioral or mental health services, and treatment for alcohol and drug abuse.
- 4. This information may be disclosed to, and used by, the following individual or organization:  
Name: \_\_\_\_\_  
Address: \_\_\_\_\_
- 5. For the purpose of \_\_\_\_\_
- 6. I understand that I have a right to revoke this authorization at any time. I understand that if I revoke this authorization, I must do so in writing and present my written revocation to the Medical Record Department. I understand that the revocation will not apply to information that has already been released in response to this authorization. I understand that the revocation will not apply to my insurance company when the law provides my insurer with the right to contest a claim under my policy
- 7. Unless otherwise revoked, the authorization will expire on the following date, event, or condition:  
\_\_\_\_\_  
If I fail to specify an expiration date, event or condition, **this authorization will expire in six months from the date of signing.**
- 8. I understand that once the information is disclosed pursuant to this authorization, it may be re-disclosed by the recipient and the information may not be protected by federal privacy regulations.
- 9. I understand that I need not sign this form in order to ensure health care treatment, payment, enrollment in my health plan, or eligibility for benefits. Or  
I understand that if I refuse to sign this form, under specific conditions the organization can refuse:  
Treatment      Enrollment in the health plan      Eligibility for benefits      Employment

_____ SIGNATURE	_____ DATE	
_____ IF SIGNED BY LEGAL REPRESENTATIVE, RELATIONSHIP TO PATIENT	_____ SIGNATURE OF WITNESS	_____ DATE