

Authorization for Release of Protected Health Information

I authorize the use or disclosure of my protected health information as described below.

Patient Name

Date of Birth

Entity Authorized to Disclose My Information: Orthopedic Associates of Hartford, P.C. (OAH)

Entity or Person to Receive My Information:

Self (patient) Physician/Clinic Attorney Insurance Other

Name: _____ Fax # (if applicable) _____

Name: _____ Fax # (if applicable) _____

Description of Information to Be Disclosed:

All medical records Laboratory results Radiology reports Billing records

Other (please specify): _____

Purpose of Disclosure:

At my request Continuing care Legal matter Insurance

Other (please specify): _____

Preferred Contact Method(s): (Check all that apply)

Home Cell Email

The office has permission to speak with the following person(s) regarding my health:

Name	Phone	Relationship	Emergency Contact
_____	_____	_____	<input type="checkbox"/>
_____	_____	_____	<input type="checkbox"/>
_____	_____	_____	<input type="checkbox"/>

Patient Acknowledgment

I understand that:

- I have the right to revoke this authorization at any time in writing.
- The revocation will not apply to information already released under this authorization.
- Information disclosed may be subject to re-disclosure and may no longer be protected by HIPAA.
- I am not required to sign this form to receive treatment (unless the disclosure is for research, payment, or eligibility determination).
- This authorization expires 1 year from the date of signature.

Patient or Legal Representative Signature

Date

If signed by a legal representative:

Name: _____ Relationship to Patient: _____