Authorization for Release of Protected Health Information

_____

Patient's Name Date of Birth Social Security Number

I authorize the user or disclosure of my protected health information by Orthopedic Associates of Hartford, P.C., ("OAH") as specified below. I understand that signing this authorization is voluntary and that OAH may not require me to sign this authorization before OAH provides me with treatment. I understand that I have the right to revoke this authorization at any time by providing a signed, written notice of such revocation to OAH. I understand that a description of my right to revoke my authorization is set forth in OAH's Notice of Privacy Practices. I understand that information is being released pursuant to this authorization at my request and that the information may no longer be protected by law or regulation and may be redisclosed by the recipient.

1. Please use or disclose the following health information, if such information exists:
   [ ] The entire medical record [ ] The following limited health information:
   _____
   _____
2. OAH cannot use or disclose certain information unless you specifically authorize such use or disclosure. Please **INITIAL** next to each item below if you specifically authorize the release of health information related to the testing, diagnosis or treatment for:
   [ ] HIV/Aids _____ [ ] Drug and/or alcohol abuse _____ [ ] Mental health/psychiatric disorders _____
3. Please specify the time period for the information you described above to be disclosed:
   [ ] All information maintained at any time by OAH, or
   [ ] Information maintained by OAH from: ___/___/___ to: ___/___/___
4. Please specify who may receive the information requested by this authorization:
   _____
   _____

In general, the HIPAA privacy rule gives individuals the right to request a restriction on their personal health information. The individual is also provided the right to request confidential communication or that communication be made by alternative means.

The office has my permission to leave a detailed message on my: (Check all that apply)
[ ] Home Phone [ ] Cell Phone

The office has my permission to speak with the following person(s) regarding my health:
Emergency Contact: _____ Phone: _____Relationship: _____
Name: _____ Phone: _____Relationship: _____
Name: _____ Phone: _____Relationship: _____

This authorization will expire one year from the date signed below, unless you specify an earlier date here: ___ /___ /___.

By signing below, I understand and acknowledge the following:

- I have read and understand this authorization;
- I am authorizing OAH to use or disclose the health information to the person(s) and for the purpose(s) identified in this authorization; and
- If I have any question about disclosure of my protected health information pursuant to this authorization, I may contact David Mudano, OAH Privacy Officer.

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Name of Individual, If different than the patient | Signature of Patient or Personal Representative | Date

If signed by the patient's personal representative, describe the legal authority of the representative to act on behalf of the patient: _____ Legal authority of representative verified by: _____