Ohio Orthopaedics & Sports Medicine, Inc.
Authorization for Use or Disclosure of Protected Health Information

Patient Name _____ **DOB** _____

I hereby authorize the use or disclosure of personal health information about me as described below.

1. Select one of the following:

☐ Request/Use my medical records from:
Physician/Office Name _____
Address _____
Phone _____ Fax _____

☐ Release/Disclose my medical records to:
Physician/Office Name _____
Address _____
Phone _____ Fax _____

2. Description of records requested (i.e. dates of service, op reports, office notes, diagnostic imaging reports, CD, etc.):

_____
_____
_____

3. The protected health information listed above is being used or disclosed for the following purpose(s):

_____
_____

4. This authorization will remain valid for 60 days from today's date or

☐ This authorization will remain valid until (specify date) _____ .

5. Please specify how the information should be disclosed:

☐ Copy and Pick Up (Notify me when records are ready. Phone_____)
☐ Mail to Patient Address _____
☐ Fax to Physician Office specified in Section 1
☐ Mail to Physician Office specified in Section 1
☐ Other _____

I understand that I have the right to revoke this authorization in writing at anytime by sending such written notification to the Business Manager / HR Manager at Ohio Orthopaedics & Sports Medicine, Inc. I understand that a revocation is not effective to the extent that Ohio Orthopaedics & Sports Medicine, Inc. has relied on the use or disclosure of the protected health information. I understand that information used or disclosed pursuant to this authorization may be subject to re-disclosure by the recipient and may no longer be protected by federal or state law. Ohio Orthopaedics & Sports Medicine, Inc. will not condition my treatment, payment, enrollment in a health plan or eligibility for benefits (if applicable) on whether I provide authorization for the requested use or disclosure. I understand 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). Refuse to sign this authorization. Receive a signed copy of this authorization.

_____ _____
Printed Name of Patient or Legal Representative | Relationship to Patient

_____ _____
Signature of Patient or Legal Representative | Date

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