



Authorized Disclosure of Private Healthcare Information

Please complete in black ink for scanning purposes.

Patient Name: _____ Date of Birth: _____

Street Address: _____

City: _____ State: _____ Zip Code: _____

Phone Number: _____ Email Address: _____

Patient Declines Email Address Entry:

Purpose: This form is used to identify family members, close friends, or other persons to whom we may disclose protected information about you or notify regarding your care. This form is effective for the duration of your care or until you provide further notice.

Instructions: List the person(s) to whom protected health information about you may be disclosed regarding your treatment. You must provide the name of the individual and their relationship to you.

Name: _____

Address: _____

Phone Number: _____ Relationship to patient: _____

Name: _____

Address: _____

Phone Number: _____ Relationship to patient: _____

Name: _____

Address: _____

Phone Number: _____ Relationship to patient: _____

Patient Signature (No one else may sign here except the patient):

I attest that protected health information related to my care and treatment may be disclosed to the person(s) identified above.

Patient Signature: _____ Date: _____

Personal Representative(s): (Minor children or adults unable to sign) List all parent(s) or legal guardians(s).

Name: _____

Address: _____

Phone Number: _____ Relationship to patient: _____

Name: _____

Address: _____

Phone Number: _____ Relationship to patient: _____

Authorized Representative Signature:

Printed Name of Authorized Representative: _____

Signature of Authorized Representative: _____

Relationship to the Patient: _____ Date: _____

Reason for signing: Patient is a minor Patient has a legal guardian Patient has an activated Power of Attorney

Redisclosure of Information by Recipient: I understand that any disclosure of information carries with it the potential for an unauthorized redisclosure, and the information may not be protected by confidentiality rules. If I have questions about disclosure of my health information, I can contact Bone & Joint Clinic’s Business Office Manager.

Right to Revoke Authorization: I understand that I have the right to revoke this authorization at any time. I understand that if I revoke this authorization, I must provide the revocation in writing to Bone & Joint Clinic. 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.

Prohibition of Conditions: Bone & Joint Clinic may not condition treatment, payment, enrollment in a health plan or eligibility for benefits based on the provision that I authorize this disclosure of my protected health information.