ARLINGTON ORTHOPEDIC ASSOCIATES, P.A.

PATIENT AUTHORIZATION FOR USE AND DISCLOSURE
OF PROTECTED HEALTH INFORMATION

I authorize Arlington Orthopedic Associates to use and/or disclose certain protected health information (PHI) about me, and acknowledge they have 15 business days after the receipt of the request to furnish that information to:

_____

_____

_____

This authorization allows Arlington Orthopedic Associates to use and/or disclose the following information:

☐☐ Entire Record

OR:

☐	Office Notes	☐	Radiology Reports	☐	Patient History
	_____ to _____	☐	MRI Reports	☐	X-Ray CD
☐	All Office Notes	☐	Hospital Reports	☐	MRI CD
☐	Prescription Information	☐	Other_____		

The following information is being used and/or disclosed for the following purpose:

☐ Self ☐ Disability ☐ Insurance Co. ☐ Attorney ☐ Other_____

I agree that a photocopy of this authorization shall be as valid as the original. I acknowledge that confidentiality cannot be guaranteed beyond this release. I understand that, if my protected health information is disclosed to a party it may be subject to re-disclosure by that party and may no longer be protected by the federal HIPAA Privacy Rule. I do not have to sign this authorization in order to receive treatment. I also understand that I have the right to revoke this authorization at anytime. I understand that if I revoke this authorization I must do so in writing and present my revocation to the individual or organization releasing my information. I understand that the revocation will not apply to information already 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. Unless otherwise revoked, this authorization expires upon completion of this request or upon the following date:_____.

_____	_____/_____/_____	_____
Print Patient's Name	Patients Date of Birth	Date
_____	(_____) _____-_____	
Signature of Patient or Legal Guardian	Telephone Number	
_____	_____	
Relationship to Patient (If Legal Representative)	E-Mail Address	

COMPLETE ONLY IF INFORMATION IS TO BE RELEASED DIRECTLY TO PATIENT: I understand that my medical record may contain reports, test results, and notes that only a physician can interpret. I understand and have been advised that I should contact my physician regarding the entries made in my medical record to prevent misunderstanding of the information contained in these entries. I will not hold Arlington Orthopedic Associates, P.A. and its Physicians liable for any misinterpretation of the information in my medical record as a result of not consulting my physician for the correct interpretation.

_____	_____	_____
Patient Name	Date of Birth	Signature of Patient or Legal Representative
_____	_____	_____
Relationship to Patient (If Legal Representative)	Witness	Date