Patient Authorization for use and Disclosure of Protected Health Information

I authorize Arlington Orthopedic Associates, P.A. to disclose certain protected health information (PHI) about me to (ex. Wife, doctor, children, etc….). Please list names and their relationship.

First and Last Name	**Relationship**
1)________________________________	___________________________
2)________________________________	___________________________
3)________________________________	___________________________
4)________________________________	___________________________

This authorization allows Arlington Orthopedic Associates to discuss the following information:

My treatment and care for – (condition):

____

____

This authorization will expire on:____
(Expiration date or Defined Event)

I understand that I have the right to revoke this authorization at anytime, to the extent that Arlington Orthopedic Associates, P.A. has taken action on it, by putting the revocation in writing and signing and dating.

_____________________________________ ______________________________
Patient's Name Date Patients date of birth

_____________________________________ ______________________________
Patient's/Authorized Signature Relationship to patient (if minor)

Revised 09/08/11