SOUTHERN ORTHOPAEDIC SPECIALISTS, P.C.

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Birmingham, AL 35209
P: 205-397-2663
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HIPAA AUTHORIZATION FORM

Patient Name: _____ **Date of Birth:** _____

Patient Address: _____ **SSN:** _____

_____ **Email:** _____

I authorize Southern Orthopaedic Specialists, P.C. to discuss my medical information with the following people:

☐ None

☐ Spouse: _____

☐ Guardian: _____

☐ Other: _____

☐ Parents: _____

☐ Mother (only): _____

☐ Father (only): _____

☐ relationship to patient: _____

I authorize Southern Orthopaedic Specialists, P.C. to contact me in the following manner(s) (check all that apply):

Home Telephone _____
☐ Okay to leave a message with detailed information
☐ Leave message with call back number only

Work Telephone _____
☐ Okay to leave a message with detailed information
☐ Leave message with call back number only

Written Communication
☐ Okay to mail to my home address
☐ Okay to mail to my work address
☐ Okay to fax to this number: _____

Email: _____

The HIPAA Privacy Act generally requires healthcare providers to take responsible steps to limit the disclosure of and requests for protected health information to the minimum necessary to accomplish the intended purpose. These provisions do not apply to uses and disclosures made pursuant to an authorization requested by the individual.

Healthcare entities must keep records of protected health information disclosures. Information provided below, if completed properly, will constitute an adequate record. Uses and disclosures of protected health information may be permitted without prior consent in an emergency.

You agree, in order for us to service our account or to collect any amounts you may owe, that we may contact you by telephone at any telephone number associated with your account, including wireless telephone numbers, which could result in charges to you. Methods of contact may include using pre-recorded/artificial voice messages and/or use of an automatic dialing device, as applicable.

ACKNOWLEDGEMENTS:

I acknowledge that I have received a copy of the Notice of Privacy Practices for Southern Orthopaedic Specialists, P.C.

_____ _____
Signature of Patient or Personal Representative **Date**

_____ _____
Personal Representative's relationship to the Patient Signature of Witness

_____
PRINT Personal Representative's Name