SOUTHERN ORTHOPAEDIC SPECIALISTS, P.C.
516 Brookwood Boulevard
Birmingham, Alabama 35209
Phone: (205) 397-2663 ◆ Fax (205) 278-0049

AUTHORIZATION TO DISCLOSE PROTECTED HEALTH INFORMATION

Patient Name: _____ DOB: _____

Medical Record Number or Social Security Number: _____

The following person or entity is authorized to disclose my medical records:

Name: _____ Phone: _____

Address: _____ Fax: _____

_____

The medical records will be disclosed to the following person or entity:

Name: _____ Phone: _____

Address: _____ Fax: _____

_____

The protected health information is being used for the following purpose(s):

_____

The type(s) of information to be used or disclosed are as follows:

□ Office Notes □ X-Ray & Imaging Reports □ History & Physical
□ Laboratory Results □ Operative Notes □ Discharge Summaries
□ All Information
□ Other: _____

□ Disclose patient information from this range of dates: _____ – _____
□ Disclose information from all encounters (from first visit to present day)

I hereby authorize the use or disclosure of information about the above named individual and I understand that:

1. I have the right to refuse to sign this authorization and the facility may not condition treatment on my willingness to sign this authorization (subject to certain exceptions).
2. I have the right to revoke this authorization at any time by sending written notification to ATTN: Privacy Officer and any revocation will be effective only to the extent that action has not been taken in reliance of my prior authorization.
3. The information used or disclosed may be subject to re-disclosure by the recipient and no longer protected by HIPAA laws.
4. This authorization will expire on the following date __/__/__ or event/condition _____
   *If I fail to specify an expiration date, event or condition, this authorization will expire six months from the date signed.

_____ _____
Signature of Patient or Representative Date

_____ _____
Relationship of Personal Representative for the Patient Signature of Witness