RSZ ORTHOPAEDICS
ORTHOPAEDIC SURGERY & SPORTS MEDICINE GROUP

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AUTHORIZATION FOR THE USE AND DISCLOSURE OF PROTECTED HEALTH INFORMATION & RECORD RELEASE

As required by the Health Insurance Portability and Accountability Act of 1996 Orthopaedics Surgery & Sports Medicine Group, P.C. (d/b/a RSZ Orthopaedics) may not use or disclosure your health information, except as provided in the Notice of Privacy Practices, without your authorization. Your signature on this form indicates that you are giving permission for the uses and disclosures described herein. You may revoke this authorization at any time by signing and dating the revocation section on your copy of this form and return it to this office.

AUTHORIZATION SECTION

I, _____ (print name) **Date of Birth:___/___/_____** hereby authorize the use and disclosure if the following health information that pertains to me. I approve sensitive information to be disclosed including but not limited to AIDS, HIV infection, Psychiatric Care/psychological assessment, treatment for drug and alcohol, ADHD/ADD – I can revoke this in writing at any time and address it with the privacy officer of the above named facility authorized to make this disclosure. I understand that the revocation does not apply to the information already released in response to the authorization. _____
(Initial here)

Check all that apply:

Records to disclose: Discharge summary ___ History and Physical ___ Progress Notes ___ Operative Notes ___ Pathology ___ Laboratory ___ Radiology ___ ECG/EKG/Other Cardio ___ Emergency ___ Other- please specify _____

Purpose of disclosure: Referral to specialist ___ Legal Investigation ___ Insurance ___ Disability Determination ___ Worker's Comp. ___ Personal _____

Mail/Telephone calls _____ I authorize RSZ Orthopaedics that they may mail or leave a message for me on the phone numbers I disclosed on my patient information form.

I authorize the following persons to make these disclosures of my health information:
Orthopaedic Surgery & Sports Medicine Group

I authorize the following person (s) to receive these disclosures of my health information: (Name and address to where you want records delivered) TO:

Name: _____ Address:_____

Phone number _____ and Fax number required: _____

I understand that information disclosed pursuant to this authorization may be re-disclosed to additional parties and no longer protected.
I understand that I may revoke this authorization at any time by signing the revocation section of my copy of this form and returning it to the practice. I future understand that any such revocation does not apply to the extent that persons authorized to use or disclose my health information have already acted in reliance on this authorization.
I understand that this authorization will automatically expire one year from the last date of service seen by this practice.
I understand that I am under no obligation to sign this authorization. I further understand that my ability to obtain treatment and my eligibility for benefits will not depend in any way whether I sign this authorization or not.
I understand that I have a right to inspect and to obtain a copy of any information disclosed pursuant to this authorization.

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

_____ _____
Description of Representative's Authority **Signature of Witness**

Paoli: 254 W. Lancaster Ave, P.O. Box 968, Paoli, PA 19301 (610)644-7755 FAX (610)644-8290
Phoenixville: 100 First Ave, Phoenixville, PA 19460 (610)933-2288 FAX (610)935-1739
Limerick: 649 N. Lewis Road, Suite 200, Limerick, PA 19468 (610)495-0099 FAX (610)495-0318
Bala Cynwyd: 100 N. Presidential Blvd, Pagoda Building, Bala Cynwyd, PA 19004 (610)644-7755 FAX (610) 644-8290