Southern Bone & Joint Specialists
P.O. Box 729 Dothan, AL 36302
(334) 793-2663 (800) 460-2663
Fax (334) 836-2232

Chart #:_____

Authorization to Use or Disclose Protected Health Information

Entire form must be completed!

I hereby authorize use or disclosure of the named individual's health information as described below:

Patient Name_____ Date of Birth: _____

Address (street, city, state, zip code)_____

Telephone Number: ( ) _____ Social Security Number:_____

The following individual or organization is authorized to make the disclosure:

From Southern Bone & Joint Specialists OR
From Other (please specify)_____

To Southern Bone & Joint Specialists OR
To Other (please specify)_____

Treatment Dates/Event:_____ Purpose of request:_____

The following information is to be disclosed *(please select an answer for each item listed).*

Yes **No**

……..Physician Notes
……..Lab Results
……..X-Ray Reports/Disc
……..MRI Reports/Disc
……..Surgery Notes
…….. Complete Record – if yes, please explain below why the complete record is necessary:
_____
……..Other_____

Re-disclosure: I understand that any disclosure of information carries with it the potential for re-disclosure and that my information might not be protected by confidentiality rules if re-disclosure occurs.
Right to Revoke: I understand that I have the right to revoke this authorization at any time. I understand that my revocation must be in writing and that the revocation will not apply to information already released based on this authorization.
Other Rights:

(a) I understand that authorizing the disclosure of this health information is voluntary. I can refuse to sign this authorization. I do not need to sign this form to assure treatment. However, if this authorization is needed for participation in a research study, my enrollment in the research study may be denied.
(b) I understand that I may inspect or obtain a copy of the information to be used or disclosed.

Expiration: _____ Unless otherwise revoked, this authorization will expire the date, event, or condition noted.
If a specific expiration date, event, or condition is not noted, this authorization will expire in six months.

X_____ **Date:**_____
SIGNATURE of Patient (or legal representative)

If signed by legal representative, relationship to patient:_____