THE ORTHOPAEDIC CENTER
A division of Centers for Advanced Orthopaedics

Date of Birth:

Appointment Date:

HIPAA AUTHORIZATION

AUTHORIZATION TO RELEASE PROTECTED HEALTH INFORMATION

Patient's Name: _____ DOB: _____

Address: _____

I hereby authorize: **The Orthopaedic Center, A Division of CAO** to disclose my protected health information in accordance with this authorization.

I authorize my protected health information be disclosed to: *(for example a family member or other physician treating you)*

_____

Please indicate the information or types of information to be disclosed:

_____

_____

☐ This authorization includes my complete health record (including all dates of service)

☐ This authorization is only for dates of service from _____ to _____.

The purpose of this authorization is to facilitate complete treatment inclusive of all of my treating physicians.

This authorization may be revoked by me at any time except to the extent that the person(s) and/or organization(s) listed above have already acted in reliance upon this authorization. If I revoke this authorization, I need to do so in writing and mail or hand deliver it to:

The Othopaedic Center, 9420 Key West Avenue, Suite 300, Rockville, MD 20850

If not revoked by me, this authorization will terminate on: **January 1st, 2019.**

I understand that I may inspect and/or copy the information to be disclosed.

I understand that this authorization is voluntary. I understand that I do not need to sign this form in order to ensure health care treatment, payment, enrollment in my health plan, or eligibility for benefits. I also understand that if I have any questions regarding the use or disclosure of my health information, I may contact the privacy officer at the health care provider authorized to disclose this information.

Information used or disclosed pursuant to the authorization may be subject to re-disclosure by the recipient and will no longer be protected by the federal regulations protecting privacy of an individual's health information under the Health Insurance Portability and Accountability Act of 1996 ("HIPAA Privacy Regulations") and other applicable federal and state law.

I understand that the information in my health record may include information or references to the existence of and/or treatment for **drug and/or alcohol abuse, mental health, (psychiatric records, psychological records, etc.) sexually transmitted diseases, tuberculosis, genetics, Hepatitis B or C, or human immunodeficiency virus (HIV) and/or acquired immune deficiency syndrome (AIDS).** This information will also be released unless I indicate by checking below that I do not want such information released:

DO NOT RELEASE _____

I DO NOT AUTHORIZE ANY PERSON TO ACCESS MY HEALTH RECORD. _____

Photocopies and facsimile copies of this Authorization shall be deemed to be originals.

_____ _____

Patient or Legal Representative Signature Date

_____ _____

Representative's authority to act on behalf of individual Witness