Authorization to Use and/or Disclose Health Information

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Patient Name: _____ D.O.B.: _____ SS#: _____

I authorize Alaska Orthopedic Specialists (AOS) to use and/or disclose my health information as identified below **to:**

_____

_____

(Please indicate the ***name*** of the recipient and the ***address and/or fax number*** to which the documents are to be sent.)

For the following purpose:

_____

_____

(Please ***describe each purpose***; if requested by patient and no purpose is identified, then may state "at the request of the individual.")

By ***initialing*** the spaces below, I specifically authorize the use or disclosure of the following health information and/or records, if such information and/or records exist:

_____Please send the entire medical record (all information) to the above named recipient.

OR

_____All hospital records (including nursing records & progress notes)
_____Operative reports
_____Medical records needed for continuity of care
_____Most recent five-year history
_____Emergency and urgent care records
_____Other: _____

_____Office chart notes
_____Laboratory reports
_____Pathology reports
_____Diagnostic imaging/X-ray reports
_____Billing statement/Full account ledger

* The following items must be initialed to be included in the use or disclosure of other health information:
_____*HIV/AIDS related health information and/or records
_____*Mental health information and/or records
_____*Genetic testing information and/or records
_____*Drug/alcohol diagnosis, treatment and/or referral information (Federal regulations require a description of how much and what kind of information is to be disclosed. Federal law prohibits the re-disclosure of such information.)

_____***Psychotherapy notes** (If this authorization is for the use and/or disclosure of psychotherapy notes, then it cannot be combined with any other authorization.)

Except to the extent that action has already been taken in reliance upon this authorization, I understand that I may revoke this authorization at any time by giving written notice to the Medial Records Department at AOS office. Unless revoked earlier, this authorization will expire **180 days** from the date of signing or _____.

(Expiration Date)

I understand that I may refuse to sign this authorization and that my refusal to sign will not affect my ability to obtain treatment, payment, enrollment or eligibility for benefits. I may inspect or copy any information to be used or disclosed under this authorization. I also understand that, if the person or entity receiving this information is not a health care provider or health plan covered by federal privacy regulations, the information described above may be re-disclosed and no long protected by these regulations. However, the recipient may be prohibited from disclosing my health information under other applicable state or federal laws and regulations. I further understand that the person(s) I am authorizing to use or disclose my information may receive compensation (either directly or indirectly) for doing so.

_____ _____
Signature of Individual or Individual's Legal Representative **Date**

_____ _____
Print Name of Legal Representative (if applicable) **Relationship to Individual**

(A copy of this signed form will be provided to the individual and/or the individual's legal representative.)