Name:
Chart:
Date:

ORTHOPEDIC ASSOCIATES OF MEADVILLE, P.C.
11277 VERNON PLACE, SUITE 200 • MEADVILLE, PENNSYLVANIA 16335 • 814-724-1252
FAX 814-337-6043

AUTHORIZATION TO USE OR DISCLOSE PROTECTED HEALTH INFORMATION

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

Patient Name _____ Date of Birth _____ Social Security Number _____

_____ Phone Number _____

The following is authorized to make the disclosure:

_ Orthopedic Associates of Meadville, PC
_ Other (please specify): _____

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

This information may be disclosed to and used by the following individual organization:

_ Orthopedic Associates of Meadville, PC
_ Other (please specify): _____

Address (street, city, state, zip code) or Email address for electronic notification: _____

Treatment dates: Any and All

Purpose of request : Patient's File

The following information is to be disclosed: (please check all that apply).

_ physicians notes
_ lab results
_ diagnostic radiology
_ other diagnostic studies
_ physical therapy reports
_ pain clinic reports
_ narrative reports
_ complete records

Sensitive Information: I understand that the information in my record may include information relating to sexually transmitted diseases, acquired immunodeficiency syndrome (AIDS), or infection with the Human Immunodeficiency Virus (HIV). It may also include information about behavioral or mental health services or treatment for alcohol and drug abuse.

Redisclosure: I understand that any disclosure or information carries with it the potential for redisclosure and that the information may then not be protected by federal confidentiality rules.

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. I understand 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 authorization to assure treatment. (b) I understand that I may inspect of obtain a copy of the information to be used or disclosed.

Expiration: Unless otherwise revoked, this authorization will expire on the following date, event or condition: (If no date, Event, or condition is specified, this authorization will expire in six months.

_____ _____
Signature of patient or legal representative Date

_____
If signed by legal representative, relationship to patient.

Shoulder Surgery, Wound Recovery, Total Joint Replacement, Spine Surgery,
Arthroscopic Surgery, Hand Surgery, Foot Surgery, Sports Medicine,
Physical Medicine and Rehabilitation, Electro Diagnostic Medicine