AUTHORIZATION FOR RELEASE OF INFORMATION

UNIVERSITY ORTHOPAEDICS

I hereby authorize the use or disclosure of my individually identifiable health information as described below. I understand that this authorization is voluntary. I understand that if the organization authorized to receive the information is not a health plan or healthcare provider, the released information may no longer be protected by federal privacy regulations.

Patient's Name: _____

Date of Birth: _____ SSN: _____

Person/Organization providing information: _____

Person/Organization receiving the information: _____
(Please include telephone and/or fax number where applicable)

Specific description of information (include dates): _____

What is the purpose of the use or disclosure? _____

I understand that my health care and the payment for my health care will not be affected by my signing this form. I also understand that I may see and copy the information described on this form if I ask for it, and that I get a copy of this form after I sign it.

This authorization will expire on _____ / _____ / _____ (DD/MM/YR)

I understand that I may revoke this authorization at any time by notifying the providing organization in writing, but if I do, it wont have any effect on any actions taken prior to the receipt of the revocation.

Signature of Patient or Patient's Representative: _____

Relationship to the patient: _____

Date: _____

- You may refuse to sign this authorization
- You may not use this form to release information for treatment or payment except with the information to be released is psychotherapy notes or certain research information. END OF AUTHORIZATION.