AUTHORIZATION TO DISCLOSE INFORMATION

Patient Name:____ Phone #____

Patient Address:____

Medical Record #:__________________________________Date of Birth:____

Other Identifier (Social Security Number):____

I hereby authorize this practice to make disclosure of my protected health information (information about me in my medical records and or financial record) as indicated below.

THIS INFORMATION IS TO BE DISCLOSED TO :

Name of Entity:

Attention of:

Street Address of Entity:

City: State: Zip:

DESCRIPTION OF INFORMATION TO BE DISCLOSED:

REASON FOR REQUESTED DISCLOSURE: ☐ Medical Records ☐ FMLA Forms ☐ Disability Forms

☐ All of the Above

TO BE READ AND SIGNED BY PATIENT:

I understand the following:

- I may revoke this authorization at any time by providing written notice to the practice.
- I may not be able to revoke this authorization if the practice has already taken action utilizing this authorization or if the authorization was obtained as a condition of obtaining insurance coverage.
- The practice will not condition treatment or payment based on my signing this authorization.
- I am signing this authorization freely.
- No one has pressured me to sign this authorization.
- The information disclosed in this authorization may be subject to re-disclosure by the practice and no longer protected by federal law
- I acknowledge that I have had the opportunity to review this authorization and understand the intent and the use.
- I have received a copy of this authorization.

Patient Signature: Date:

Signature of Patient's Representative: Relationship: Date:

"Tidewater Orthopaedics complies with applicable Federal civil rights laws and does not discriminate on the basis of race, color, national origin, age, disability, or sex."

FOR OFFICE USE ONLY: Event/Date Upon which Authorization will Expire: