HIPAA Privacy Authorization Form
Authorization for Use or Disclosure of Protected Health Information

Patient Name: ____ Date of Birth:____________

I authorize the use or disclosure of any of my health information from my office visits with Dr. Frank Thomas and Dr. Jerome Piontek. This includes progress notes from office visits, x-ray and high-tech imaging results (such as MRI or CT), blood test results or other specialized testing results, and operative notes.

This information will **ONLY** be shared with the following individuals, *should they call* with any questions about my visit with Dr. Thomas or Dr. Piontek.
(**People often listed include family, friends, coaches, athletic trainers, primary care/specialty physicians, etc.**)

Name/relationship:

Name/relationship:

Name/relationship:

Name/relationship:

This health information for which I am authorizing disclosure will be used for the following purpose:
_____**my personal record** (to assist others with your care)
_____**sharing with other health care providers as needed** (in the event you are referred to another physician for treatment)
_____**other** (be specific)

I understand that I have a right to revoke this authorization at any time. I understand that if I revoke this authorization I must do so in writing and present my written revocation to Central Orthopedics and Sports Medicine, PC. I understand that the revocation will not apply to information that has already been released. I understand that the revocation will not apply to my insurance company when the law provides by insurer with the right to contest a claim under my policy.

This authorization will remain on file to be updated annually.

I understand that once the above information is disclosed, it may be re-disclosed by the recipient and the information may not be protected by federal privacy laws or regulations.

I understand that authorizing the use or disclosure of information identified above is voluntary. I need not sign this form to ensure healthcare treatment.

Signature:_______________________________________ Date:______________

If a minor, a parent/guardian must sign, and if signed by a legal representative, please list relationship.

Signature:_______________________________________
Relationship:____________________________________ Date:_______________