

**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 or Dr. Brown. 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.

**(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: \_\_\_\_\_