Amount paid $_____

$10.00 fee per form

Authorization to Disclose Protected Health Information

Description of "Protected Health Information" to be Disclosed

I hereby authorize the **Orthopaedic Institute of Ohio** ("OIO") to disclose "Protected Health Information" about me or my child, specifically, **ANY MEDICAL RECORDS OR INFORMATION CONCERNING MEDICAL CONDITION OR CARE RECEIVED AT OIO BE SENT DIRECTLY TO THE ENTITY OR ENTITIES LISTED BELOW.**

My Protected Health Information will be disclosed to the entities, person(s) or classes of persons that I designate below for purposes of processing my claim for benefits or educational program: ***Check and complete ALL that apply:***

Employer_____ **Pick-Up** ☐ **mail** ☐ **OR fax #** _____

My Insurer(s) _____ **Pick-Up** ☐ **mail** ☐ **OR fax #** _____

Other _____ **Pick-Up** ☐ **mail** ☐ **OR fax #** _____

My Rights

I understand that I have the right to refuse to sign this Authorization to release my Protected Health Information. If I refuse to sign this Authorization, OIO will in no way deny me my rights concerning treatment, payment for services, enrollment in a health plan or eligibility for benefits.

I understand that I may revoke this Authorization at any time after I have signed it by providing OIO with a written statement that I wish to revoke this Authorization. My revocation of Authorization will be effective immediately and my Protected Health Information can no longer be disclosed pursuant to this Authorization except to the extent that disclosures have already been made in reliance upon this Authorization.

I specifically authorize this use/disclosure of Protected Health Information as set forth in this Authorization. I understand that if my (my child's) Protected Health Information is disclosed, then this information may be subject to redisclosure by the recipients and may no longer be protected by the federal patient privacy laws.

This Authorization, unless I earlier revoke it, shall remain in effect until three (3) years after the date entered below.

A COPY OR FAX OF THIS AUTHORIZATION SHALL BE TREATED AS AN ORIGINAL

_____ _____

Patient's Signature* Date

_____ _____

Print/Type Patient's Name Date of Birth

*If this Authorization is signed by a legal representative of the patient (for example, the parent or legal guardian if the patient is a minor) a description of such representative's authority to act for the patient must also be provided (check applicable box and/or explain your authority to sign for the patient below). Except for legal representatives acting in the capacity as a parent to the patient, also attach a copy of documentation giving you the authority to sign this Authorization on behalf of the patient.

__ Parent
__ Guardian
__ Power of Attorney
__ Health Care Proxy or Surrogate
__ Administrator/Executor of Estate

Note: A copy of this signed Authorization must be provided to the individual signing the document.