

**AUTHORIZATION TO USE OR DISCLOSE
PROTECTED HEALTH INFORMATION**

(Please Fill Out Completely)

I hereby authorize Perimeter Orthopaedics to use or disclose my health information as follows:

Patient Name: _____ Date of Birth: _____
Address (Street, City/State, Zip): _____
Phone: _____ SSN (last 4 digits): _____
Date(s) of Service: _____

Information To Be Released – Covering the Periods of Health Care

From (date) _____ To (date) _____

Please check type of information to be released:

<input type="checkbox"/> Complete health record	<input type="checkbox"/> Office Notes Only	<input type="checkbox"/> Physical Therapy Notes
<input type="checkbox"/> Laboratory test results	<input type="checkbox"/> Itemized Billing Statement	<input type="checkbox"/> X-ray films / images (fee may apply)
<input type="checkbox"/> Other (specify)	<input type="checkbox"/> Surgical Notes	

Purpose of Request:

<input type="checkbox"/> Treatment or consultation	<input type="checkbox"/> At the request of the patient	<input type="checkbox"/> Billing or claims payment
<input type="checkbox"/> Other (specify)		

RECIPIENT INFORMATION

I am requesting that the records identified above be handled in the following manner:

Mail To Address Listed Above I will pick-up Fax Number/Attn: _____
 A Representative will pick-up on my behalf (list name of Representative) _____
Mail information to : Clinic Dr. Office Self
Name/Address/Phone: _____

This request is for the purpose of: _____

I understand that I have the right to revoke this authorization at any time. I understand that my revocation must be in writing and addressed to the privacy officer of the above named facility authorized to make the disclosure. I understand that the revocation does not apply to information that has already been released in response to this authorization. Unless otherwise revoked this authorization will expire in six months.

I understand that any disclosure of information may be subject to re-disclosure by the recipient and may no longer be protected by Federal or State law. I understand that authorizing is voluntary. I understand that if I have any questions about disclosure of my health information, I may contact the privacy officer at the facility listed above that is authorized to disclose this information and request a copy of this authorization.

I understand that the information in my health record may include information pertaining to treatment of drug and alcohol abuse, mental health, acquired immunodeficiency syndrome (AIDS), or human immunodeficiency virus (HIV), sexually transmitted diseases, tuberculosis information or genetics. THIS INFORMATION WILL ALSO BE RELEASED UNLESS YOU INDICATE: _____ DO NOT RELEASE (Indicate with a check mark).

Signature of Patient or Authorized Representative

Date