



Daouk Orthopaedics
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AUTHORIZATION FOR THE USE AND DISCLOSURE OF PROTECTED HEALTH INFORMATION

_____ hereby authorizes the use or disclosure of the individually
Print Patient/Legal Representative or Parent/Legal Guardian Name

Identifiable health information of _____ as described herein.
Print Patient Name Date of Birth

Person/organization authorized to use/disclose the information: Name/organization _____ Address _____ City, State, Zip _____ Phone _____ Fax _____	Person/organization authorized to receive the information: Name/organization _____ Address _____ City, State, Zip _____ Phone _____ Fax _____
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For the purpose of: Legal Request Moving out of Area New Local Physician Other (please specify)

This authorization will expire on the following date, event or condition: _____
 If I fail to specify an expiration event or condition, the authorization will expire in one year. I understand that this authorization is revocable upon written notice to the office where the original authorization is retained, except to the extent that action has already been taken on this authorization. Mental health, alcohol, drug, HIV and/or AIDS information is confidentially protected by Federal and state law which prohibits disclosure without specific written authorization of the undersigned, or as otherwise permitted by such regulations. I further request that no genetic counseling/testing information in my record be released without my written authorization, except as otherwise required by law. I understand that I may select the information from the list below to be released by placing my initials in the space provided. Furthermore, I understand that any disclosure of information from my records carries with it the potential for an unauthorized re-disclosure of my health information. I further understand that Physician Associates, LLC may not condition the provision of treatment, payment, enrollment in the health plan, or eligibility for benefits on the provision of this authorization.

Date(s) of Service: From: _____ To: _____

Place your **INITIALS** by each item to be released or reviewed:

- | | | |
|---|-----------------------------------|-----------------------------------|
| ___ Abstract of Record | ___ All diagnostic test results | ___ Pathology/Operative Report(s) |
| ___ Radiology only | ___ Consultation/Progress Note(s) | ___ Lab only |
| ___ Complete Record (charges may apply) | | ___ Other (specify) _____ |

In addition, place your **INITIALS** by each specific item: (if applicable)

- | | | |
|-------------------------|----------------------|--|
| ___ Mental Health | ___ HIV Testing | ___ Genetic Counseling/Testing Information |
| ___ Drug and/or Alcohol | ___ AIDS Information | ___ STD/Communicable Diseases |

Patient/Legal Representative or Parent/Legal Guardian *Signature Required* Date of Authorization

Patient Date of Birth Social Security Number (optional) Identification Shown

Translator or Interpreter's Name Telephone Number

Address City State Zip Code

Official Use Only: _____
Name of Person Releasing Information Date