Any questions call 814-456-6022
Please fax back
814-456-7040

AUTHORIZATION FOR USE/DISCLOSURE OF HEALTH INFORMATION

I authorize **Hand, Microsurgery and Reconstructive Orthopaedics, LLP** to use and/or disclose my health information as stated below.

1. I understand and acknowledge that this authorization extends to all or any part of my records, which may include treatment for physical or psychiatric conditions; HIV/AIDS test results or diagnoses and or alcohol/drug abuse. I expressly consent to the release of all information unless otherwise stated below:

_____

2. **Hand, Microsurgery and Reconstructive Orthopaedics, LLP** is authorized to disclose this health information to the following person(s):

Name: _____Fax #:_____

Address: _____

City/State/Zip Code: _____

3. This Authorization expires on _____.
(Date or event)

4. I understand that I have the right to revoke this Authorization at any time. I may not revoke it to the extent that Hand, Microsurgery and Reconstructive Orthopaedics, LLP has already relied upon it, or if this Authorization was signed as a condition of obtaining insurance coverage. In order to revoke this Authorization, I understand that I must revoke it in writing to Hand, Microsurgery and Reconstructive Orthopaedics, LLP.
Hand, Microsurgery and Reconstructive Orthopaedics, LLP has forms for you to use if you wish to revoke this Authorization at any time before it expires.

5 I understand that information used or disclosed under this Authorization could potentially be re-disclosed by the person receiving the information, and may no longer be subject to the privacy protections provided to me by law.

6. I understand that Hand, Microsurgery and Reconstructive Orthopaedics, LLP may not require that I sign this Authorization in order to obtain treatment.

Hand, Microsurgery and Reconstructive Orthopaedics, LLP is authorized to obtain, use and/or disclose the information described above for the following purpose(s) (Why you need your records):

_____

Date: _____ Signature: _____

Print patient's full name: _____ _____

Patient's DOB: _____

If you are the legal representative of the person listed above, please check off the basis for your authority:

- ☐ Power of Attorney (attach copy)
- ☐ Guardianship Order (attach copy)
- ☐ Parent of Minor
- ☐ Other: _____

For Office Use Only

Patient ID No_____

Physician: _____