INCOMPLETE FORMS CANNOT BE ACCEPTED OR PROCESSED

PATIENT AUTHORIZATION FOR USE AND DISCLOSURE OF PROTECTED HEALTH INFORMATION

By signing this authorization, I authorize OrthoArkansas to use and/or disclose certain protected health information (PHI) about me to: _____

Fax: _____

Email: _____

Address: _____

Name, address and phone number of entity to receive this information

This authorization permits OrthoArkansas to use and/or disclose the following individually identifiable health information about me (specifically describe the information to be used or disclosed, such as date(s) of services, type of services, level of detail to be released, origin of information, etc.):

This authorization applies to the following dates of service or specific injury _____

- ❑ Patient Demographic Sheet
- ❑ Progress Notes
- ❑ Physical Therapy Progress Notes
- ❑ Blood Tests
- ❑ MRI Reports
- ❑ Bone Scan Reports
- ❑ Operative Report
- ❑ History & Physical
- ❑ Disability Paperwork
- ❑ Discharge Summary
- ❑ Bone Density Measurement
- ❑ Record Requests
- ❑ EMG Nerve Conduction Study
- ❑ CT Scan
- ❑ Consultations
- ❑ X-ray Reports
- ❑ Pathology Reports
- ❑ Prescription Copies
- ❑ Other _____

The information will be used or disclosed for the following purpose:

- ❑ Medical Care
- ❑ Insurance
- ❑ Attorney
- ❑ Other _____

If requested by the patient, purpose may be listed as "at the request of the individual". The purpose(s) is/are provided so that I can make an informed decision whether to allow release of the information. This authorization will expire on _____ (Expiration date or Defined Event). If no date given, authorization will remain in place until OrthoArkansas is notified of a change request.

I do not have to sign this authorization in order to receive treatment from OrthoArkansas. In fact, I have the right to refuse to sign this authorization. When my information is used or disclosed pursuant to this authorization, it may be subject to redisclosure by the recipient and may no longer be protected by the federal HIPAA Privacy Rule. I have the right to revoke this authorization in writing except to the extent that the practice has acted in reliance upon this authorization. This practice may in some cases receive payment for disclosing this patients' protected healthcare information. My written revocation must be submitted to Medical Records at OrthoArkansas, 800 Fair Park Blvd, Little Rock, AR 72204.

_____	_____
Signature of Patient or Legal Guardian	Relationship to Patient
_____	_____
Patient's Name	Date
_____	_____
Print Name of Patient or Legal Guardian	Date of Birth