CHIPPEWA VALLEY
ORTHOPEDICS AND
SPORTS MEDICINE

Authorization For Disclosure of Health Information

Name of Patient _____ Birth Date _____

Street Address _____ City, State, Zip Code _____

I hereby authorize:

Name _____

Street Address _____

City, State, Zip Code _____

To disclose my protected health Information, as described below, to:

Name of Individual or Entity _____

Street Address _____

City, State, Zip Code _____

Information to be released:

_____ Medical History, Examination Reports

_____ Surgical Reports

_____ Xray Reports

_____ Xray Films

_____ Laboratory Reports

_____ Other (Please Specify)_____

_____

Purpose of the use or disclosure:

_____ At the request of the individual

_____ Other (Please Specify)_____

I understand that I have the right to:

- Inspect or copy the information to be used or disclosed.
- Receive a copy of this authorization
- Revoke this authorization at any time. I understand that the revocation will not apply to information that has already been released in response to this authorization

I understand that any disclosure of information carries with it the potential for an unauthorized re-disclosure and the information may no longer be protected by federal privacy regulations.

I understand that my healthcare and payment for my healthcare will not be affected if I do not sign this form.

Unless otherwise revoked, this authorization will expire on:_____

_____ _____

Signature of patient Date

_____ _____

Signature of personal representative, person authorized by the patient, or other legal authority

Relationship/legal authority