AUTHORIZATION FOR DISCLOSURE OF PROTECTED HEALTH INFORMATION
ROTHMAN ORTHOPAEDIC SPECIALTY HOSPITAL

PLEASE PRINT ALL INFORMATION EXCEPT FOR REQUIRED SIGNATURES.

PATIENT NAME: ______________________________ **DATE OF BIRTH:** ________________
PATIENT'S ADDRESS: ____
CITY/STATE/ZIP: ____
PHONE # for us to CONTACT YOU IF WE HAVE ANY QUESTIONS: **Home:** ____________________ **Cell:** ____________________

Disclosure of protected health information is made at my request for:

- ☐ Change of Insurance
- ☐ Referral
- ☐ Other______________________
- ☐ Change of Physician
- ☐ Personal health records
- ☐ Legal or Attorney Use

DESCRIBE WHAT SPECIFIC RECORDS MAY BE DISCLOSED/CHECK ALL THAT APPLY:

- ☐ All Records*
- ☐ Records from (date) ____________ to (date) ____________
- ☐ Billing Records/Statements for Services
- ☐ Labs and Diagnostic test results only
- ☐ Discharge Summary ONLY
- ☐ Physician's Progress Notes, History & Physical and Operative Report/Procedure Notes
- ☐ Other/please provide specific information: ______________________________

***** *"All records"* means all protected health information in a designated record set, which includes but is not limited to patient family histories, genetic information, inpatient/outpatient records, medical, dental, psychiatric, alcohol/chemical/substance abuse, HIV/AIDS, pharmaceutical, hospital or physician records, office notes, narrative summaries, correspondence to/from/about me, diagnostic testing results, bills, statements & invoices and information from all other health care providers used for our care and treatment in the hospital/facility. Some records have Federal Privacy Protections. This does not include psychotherapy notes, which require separate "authorization to disclose".

Persons, facility, or class of persons who are authorized *to disclose (provide)* the records/information:

- ☐ **ROTHMAN ORTHOPAEDIC SPECIALTY HOSPITAL**
- ☐ Other: ______________________________

Persons, facility, or class of persons who are authorized *to receive* the records/information:

Physician/Hospital/Other/Self: ______________________________
Attorney/Law Firm: ______________________________ **N/A** ☐
Address______________________________
City/State Zip______________________________
Phone #______________________________

Please complete more than one form if multiple disclosures to multiple providers are requested.

I hereby authorize the disclosure of the information described. I understand that if the person or entity that receives the described records/information is not a health care provider or health plan covered by federal privacy regulations, the records/information may be redisclosed and no longer protected by those regulations. I also understand that certain records may be protected by federal or state law, and I am requesting that any and all such protected records be released under this authorization. If I revoke this authorization, it will have no effect on actions taken or information already sent as authorized by his form. I also understand that the hospital/facility will not condition treatment, payment, enrollment or eligibility on whether I sign the authorization. I also understand that I may have a copy of this form after I sign it. I also permit disclosure of information upon presentation of a photocopy of this authorization. I understand that I have the right to revoke this authorization. I may do so by delivering or mailing a written revocation to this facility/hospital, any other healthcare provider or attorney or law firm if named above. Unless otherwise revoked, the authorization will expire on the following date, event or condition____________________. ***If a specific expiration date, event or condition is not indicated, this authorization will expire 1 (one) year from date signed.***

I have read and understand this form. I am the patient listed or am authorized to act on behalf of the patient as the patient's personal representative *(if personal representative has Power of Attorney, please be prepared to provide documentation of such form)*

______________________________ ____________________
Signature of Patient (or Patient's Personal Representative, if applicable) **Date of Signature**

Personal Representative's Relationship/Capacity to Patient: ______________________________

Printed Name of Personal Representative: ______________________________

Printed address & telephone number of Personal Representative: ______________________________