Augusta Orthopedic and Sports Medicine Specialists, P.C.

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AUTHORIZATION FOR USE AND DISCLOSURE OF INFORMATION

I hereby authorize the use or disclosure of my individually identifiable health information as described below. I understand that this authorization is voluntary. I understand that if the organization authorized to receive the information is not a health plan or a health care provider, the released information may be redisclosed and may no longer be protected by federal privacy regulations.

Patient Name: ______________________________ **DOB:** ______________

Patient Phone: ______________________________

Persons/Organizations authorized to release the information: ______________________________

Persons/Organizations authorized to receive the information: ______________________________

Specific description of information (including date (s)): ______________________________

____

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The patient or the patient's legal representative must read and initial the following statement:

1. I understand that this authorization will expire ______________ Initials: __________

2. I understand that I may revoke this authorization at any time by notifying the providing organization in writing, but if I do it will not have an effect on any actions taken before the organization received the revocation.

Initials: __________

To Be Completed by Augusta Orthopedic and Sports Medicine Specialists, P.C.:

1. The purpose of the use or disclosure is: ______________________________

2. The information will be used in the following manner: ______________________________

3. Augusta Orthopedic and Sports Medicine Specialists, P.C. will not receive direct or indirect remuneration or disclosing the information listed above.

NOTICE TO PATIENT: The patient or the patient's legal representative may inspect and/or copy the protected health information to be disclosed in accordance with Augusta Orthopedic and Sports Medicine Specialists, P.C. access policies.

Augusta Orthopedic and Sport Medicine Specialists, P.C. does not limit its right to make use or disclosure of your information that is required by law or permitted to avert a serious threat to the health or safety to the public.

****PLEASE ALLOW A MINIMUM OF 10 AND UP TO A MAX OF 30 WORKING DAYS FOR RECORDS TO BE COPIED. THERE IS A COPY FEE OF .97 CENTS PER PAGE.**

______________________________ ______________
Signature of Patient or Legal Representative **Date**

______________________________ ______________
Printed Name of Patient's Representative **Relationship**

YOU MAY REFUSE TO SIGN THIS AUTHORIZATION.

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