

Orthopedic Group of Birmingham, P.C.
Authorization to Disclose Health Information
PHONE (205) 939-0610 FAX (205) 930-9134

Patient Name: _____ Dob: _____ Social Security Number: _____

1. I authorize Orthopedic Group of Birmingham to use or disclose the above named individual's health information as described below.
2. The type and amount of information to be used or disclosed is as follows: (include dates where appropriate)

- | | |
|---|--|
| <input type="checkbox"/> Problem list | <input type="checkbox"/> Patient Account Statement/Billing Records |
| <input type="checkbox"/> Medication list | <input type="checkbox"/> _____ |
| <input type="checkbox"/> List of allergies | <input type="checkbox"/> _____ |
| <input type="checkbox"/> Most recent history and physical | |
| <input type="checkbox"/> Most recent discharge summary | |
| <input type="checkbox"/> Laboratory results | From (date) _____ to (date) _____ |
| <input type="checkbox"/> X-ray and imaging reports | From (date) _____ to (date) _____ |
| <input type="checkbox"/> Consultation reports | From (doctors' names) _____ |
| <input type="checkbox"/> Entire record | _____ |

Other: _____

3. I understand that the information in my health record may include information relating to sexually transmitted disease, acquired immunodeficiency syndrome (AIDS), or human immunodeficiency virus (HIV). It may also include information about behavioral or mental health services, and treatment for alcohol and drug abuse.
4. This information may be disclosed to and used by the following individual or organization:
Address: _____
For the purpose: _____
 At the request of the individual
5. I understand that I have the right to revoke this authorization at any time. I understand that if I revoke this authorization I must do so in writing and present my written revocation to Darren Turner, Privacy/Security Officer. I understand that the revocation will not apply to information that has already been released in response to this authorization. I understand that the revocation will not apply to my insurance company when the law provides my insurer with the right to contest a claim under my policy. Unless otherwise revoked, this authorization will expire on the following date, event, or condition: _____. If I fail to specify an expiration date, event or condition, this authorization will expire in six months.
6. I understand that authorizing the disclosure of this health information is voluntary. I can refuse to sign this authorization. I need not sign this form in order to assure treatment. I understand that I may inspect or copy the information to be used or disclosed, as provided in CRF 164.524 of the Federal Register Rules and Regulations. I understand that any disclosure of information carries with it the potential for an unauthorized redisclosure and the information may not be protected by federal confidentiality rules. If I have questions about disclosure or my health information, I can contact Darren Turner, Privacy/Security Officer.