Authorization for PHI Disclosure

Sewickley Foot and Ankle
1099 Ohio River Blvd, Sewickley, PA 15143
P: 412-741-4470 F: 412-741-1332

This Authorization for PHI Disclosure Form only needs to be completed if you would like to appoint a personal representative with whom **Sewickley Foot and Ankle** (**SFA**) may discuss your private health information and benefit coverage.

Your privacy is important to us, as are your rights. To ensure that your health information is properly protected, we need to have written confirmation of the details of your request to appoint a personal representative. Please provide the requested information about yourself and the person (or entity) you are designating as your representative. Completing and submitting this form does not affect your enrollment, eligibility, or benefits. You have the right to cancel this designation at any time in writing.

Note: We may discuss your health information with your personal representative. Please read this form carefully and fill it out completely.

Member Verification – (Please print)

Member Name: _____ Date of Birth: _____

Phone number: _____

Address: _____

Records to be disclosed – (check all that apply):

Please indicate what information you wish to release by checking one or more of the boxes below.

☐ All Records ☐ Only limited information

If you selected “Only limited information,” check all that apply.

☐ Information about benefits ☐ Information about your claims
☐ Information about premium payments ☐ Medical records

Indicate by check and initial which highly protected information you allow us to share if any of the boxes below are checked.

_____ ☐ Drug/Alcohol Diagnosis, Treatment & Referral
_____ ☐ HIV/AIDS information

Purpose of this release of information

☐ At the request of the individual
☐ Litigation
☐ Other (please describe): _____

Expiration of Authorization

Check only one box below indicating how long SFA can use this authorization to disclose your personal health information (subject to applicable law – for example, your State may limit how long Medicare may give out your personal health information):

☐ Disclose my personal health information indefinitely
☐ Disclose my personal health information for a specified period only

Beginning : _____ Ending: _____
(mm/dd/yyyy) (mm/dd/yyyy)

Entity or person authorized to receive information

Name: _____ Phone number: _____

Address of individual or company authorized to receive the information:

_____

Check the box describing the person/organization's relationship to you.

☐ Family Member
☐ Friend
☐ Doctor or health care provider
☐ Other, please describe

Please note:

- SFA cannot control what your personal representative does with the information disclosed to him or her, including whether your personal representative discloses the information to third parties, which could result in the information no longer being protected by federal privacy regulations.
- You may change or revoke this request by sending a written request to SFA. Please note that such revocation will not be effective until SFA receives and processes the notification.
- The provision of treatment, payment enrollment or eligibility for benefits does not depend on whether you sign this authorization.

By signing this form, I attest that I have read and understand the above information. My signature authorizes the disclosure of the information described.

Signature of Member, Personal Representative or Parent/Guardian who is authorizing the release:

Signature: _____ Date: _____

We recommend that you keep a copy of your completed form for your records. A copy will be retained by SFA and made available upon your request.