PediOrthoSA

I understand Pedi Ortho SA is authorized by me to use or disclose my Protected Health Information for a purpose other than treatment payment, or health care operations. I have read this authorization and understand what information will be used or disclosed, who may use and disclose information, and the recipient(s) of that information. I understand that treatment, payment, enrollment, or eligibility for benefits may not be conditioned upon me signing this authorization.

I specifically authorize Pedi Ortho SA or his/her designated employees to disclose my Protected Health Information as described on this form to the recipients listed below. I understand that when the information is used or disclosed pursuant to this authorization, it may be subject to re-disclosure by the recipient and may no longer be protected by state or federal privacy regulations. I further understand that I retain the right to revoke this authorization, if done so according to the steps set forth.

Patient Name_____ Date of Birth_____
Address_____
(CITY) (STATE) (ZIP)

Authorizes Pedi Ortho SA to release the following medical information to:

Name of Person/Facility_____
Address_____
_____
(CITY) (STATE) (ZIP)

Phone _____ Fax_____

Check items that may be released:

___HISTORY
___LAB REPORTS
___OPERATIVE REPORTS
___X-RAY
___PROGRESS REPORTS
___DIAGNOSTIC REPORTS
___OTHER (SPECIFY)_____
___FMLA Documents

This authorization is for the purpose of:
___Continuation of Care ___Attorney ___Insurance ___Other (Specify)_____

This authorization shall be valid for 120 days from the date of signature. The patient can revoke this authorization in writing at any time prior to the expiration date.

_____ _____
PATIENT/PATIENTS REPRESENTATIVE NAME DATE

_____ _____
SIGNATURE DATE

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