Authorization for Release of Protected Health Information

- Federal law says that we cannot share your health information without your permission except in certain situations. If you sign this form, you are giving us permission to share your health information with the person you have indicated below.
- This authorization is voluntary.
- Right to revoke: If you decide you do not us to share your health information any longer, sign the revocation at the end of this form and give this form to the front desk. If we have shared your health information for a research study, we may continue to use or share your health information for that purpose only.
- Payment, enrollment, or eligibility for benefits for your health care will not be affected if you do not sign this authorization, unless the disclosure is for eligibility or enrollment determinations, or for risk determinations.
- We cannot promise that the person you permit us to share your health information with will not share your health information with someone else you may not want to have your health information.
- You can keep a copy of this authorization, and can contact our Privacy Officer to get a copy if you do not have one.

Patient Name: _____

Social Security Number: _____ **DOB:** _____

I authorize **Naples Orthopedics** to share my health information with:

Practice / Name: _____

Address: _____

Phone: _____

My health information may be shared for the purpose of:

____ Physician Referral ____ Financial ____ Personal
____ Legal ____ Insurance ____ Other

Explain Other: _____

I request that the following health information be shared:

____ Entire medical record ____ Lab reports ____ Appointment dates

____ One year of history ____ Diagnostic films/reports ____ Treatment plans/referrals

____ Three year history ____ Office reports/notes ____ Financial/billing information

____ Other: _____

The following sensitive information must be specifically initialed to be included:

____ HIV/AIDS records ____ Mental health information ____ Domestic Violence

____ HBV / TB related records ____ Drug / Alcohol treatment* ____ Genetic information / testing

*Federal regulations require a description of what kind of information and how much is to be disclosed.

I understand, if a person or entity receives my personal health information is not a health care provider or health plan the information described above may be re-disclosed and no longer protected by the HIPAA Privacy regulations. However, the recipient is prohibited from disclosing substance abuse information under the Federal Substance Abuse Confidentiality Requirements.

The person I am authorizing to use and/or disclose the information may not receive compensation for doing so.

I also understand that I may refuse to sign this authorization and my refusal to sign will not affect my capacity to obtain treatment or payment of eligible benefits.

This authorization will expire on _____, unless otherwise revoked.

This form must be signed by EITHER the recipient OR by the personal representative. The recipient's parent may sign for the recipient if the recipient is a minor.

Signature of Patient:_____ Date:_____

If this form is signed by the personal representative, please include a copy of the document naming the personal representative, for example, a Power of Attorney, Personal Representative Designation form, or order appointing a guardian or executor.

Signature of Personal Representative:_____ Date:_____

Relationship to Patient:_____