AUTHORIZATION TO RELEASE MEDICAL INFORMATION TO OTHER INDIVIDUALS

Patient Name: _____ Date of Birth: _____

Social Security Number: _____ Account Number: _____

I hereby authorize the medical providers and personnel of Crescent City Orthopedics to discuss my protected health information via voicemail of contact number listed (**YES OR NO**), and with the following person(s):

_____ _____
Relationship *Name*

_____ _____
Relationship *Name*

_____ _____
Relationship *Name*

I understand that certain information cannot be release without specific authorization as required by state or federal law. By initialing the lines below, I authorize the release of the following protected or sensitive information:

_____ Information regarding the patient's diagnosis and treatment from Crescent City Orthopedics

_____ Office notes from a visit at Crescent City Orthopedics

_____ Surgical / operative treatment by a provider at Crescent City Orthopedics

_____ Medication history / treatment by a provider at Crescent City Orthopedics

This authorization shall be in force and in effect from _____ until _____ at which time this authorization to use or disclose my protected health information expires.

Unless specified above, this authorization will expire 365 days from the date of signing.
I understand that I have the right to revoke this authorization, in writing, at any time.
I understand that such revocation is not effective to the extent that the Clinic has relied on the use or disclosure of the protected health information.
I understand that information used or disclosed pursuant to this authorization may be subject to re-disclosure by the recipient and may no longer be protected by federal or state law.
I understand that I have the right to refuse to sign this authorization.

_____ _____
Patient / Guardian *Date*