AUTHORIZATION FOR THE RELEASE OF PROTECTED HEALTH INFORMATION

Section A: U.S. GOVERNMENT REGULATIONS REQUIRE THIS FORM BE COMPLETED AND SIGNED BEFORE ANY MEDICAL RECORDS WILL BE RELEASED AND *RETAINED ON FILE FOR 6 YEARS*.

I hereby authorize the use or disclosure of my individually identifiable health information as described below. I understand that this authorization is voluntary. I understand that if the organization authorized to receive the information is not a health plan or a health care provider, the released information may no longer be protected by federal privacy regulations and therefore I release University Orthopedics, its employees, and my physicians from all liability arising from disclosure of my health information.

Patient Name: _____ DOB: _____ ACCOUNT # _____

Address: _____ Phone # _____

Persons/organizations providing the information:

UNIVERSITY ORTHOPEDICS, INC.

2 DUDLEY STREET, SUITE 200

PROVIDENCE, RI 02901

Persons/Organizations authorized to receive:

_____

_____

_____

***Specific* information REQUESTED including dates:**

_____

_____

_____

Purpose of disclosure:

_____

Or IF APPLICABLE:

Circle: ENTIRE MEDICAL RECORD

Section B: Must be completed for all authorizations: **Please check one:** I hereby ___ CONSENT ___ REFUSE to the release of protected health information concerning: Mental Health, Alcohol and/or drug use, sexual abuse, sexually transmitted diseases, AIDS or HIV test results. *(These may or may not be part of your record at University Orthopedics).*

Section C: Must be completed for all authorizations: **The patient or the patient's representative must read and initial the following statements:**

1. I understand that this authorization will expire one year from the date below. Initials: _____
2. I understand that *I may revoke* this authorization at any time by notifying the providing organization in writing, but if I do, it won't have any effect on any actions taken prior to the date of the revocation. Initials: _____

Signature of patient or patient's representative (Power of Attorney must be on record)

_____ Date: _____

Printed name of patient or patient's representative _____

Relationship to patient (if applicable): _____

YOU MAY REFUSE TO SIGN THIS AUTHORIZATION