Premier Orthopedics, PC

2405 Osler Court, Albany, GA 31707 (229) 435-1458, Fax (229) 317-2362
316 East 16th Ave, Cordele, GA 31015 (229) 273-1730, Fax (229) 273-6732

Patient Authorization for Use and/or Disclosure of Protected Health Information

Patient Name:		Pt Account #:
Address:		
SSN:	Date of Birth:	Contact #:

I hereby authorize Premier Orthopedics, PC, to use, release and/or receive my Health Information as follows:

☐ **Use** the following health information maintained by Premier Orthopedics, PC

☐ **Release** the following health information to: _____
_____

☐ **Receive** the following health information from: _____
_____

Please select the items that apply to this request:

☐ Clinic or Office Notes _____
☐ Hospital Admission and/or Discharge Notes
☐ X-Ray Images / Report (circle)
☐ MRI Images / Report (circle)
☐ Emergency Room Notes
☐ Disability Forms
☐ All Records on File
☐ Other _____

Last Surgery Date: _____ (to be completed by Premier Staff)

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By providing this Authorization, I understand as follows:

1. I understand that this Authorization is voluntary. I may refuse to sign this Authorization and my treatment and/or payment obligation will not be affected.
2. I understand that the health information to be released may be subject to re-disclosure by the recipient of the health information and no longer protected by the Federal Privacy Rules.
3. I understand that I may revoke this Authorization at any time by notifying Premier Orthopedics, PC in writing, but if I do, it will not have any effect on uses or disclosures prior to the receipt of the revocation.
4. I understand that I will receive a copy of this Authorization form after I sign it.
5. I understand and agree to be financially responsible for any fees associated with this records request and that such fees must be paid prior to the release of records.
6. I understand that this Authorization will terminate one year from the date of my signature unless a different date or expiration date is stated. Specific date: _____

_____ _____
Signature of Patient or Patient's Representative Date

_____ _____
Printed Name of Patient's Representative (*if applicable*) Representative's Relationship to Patient (*if applicable*)