

**SOUTH BEND ORTHOPAEDIC
SPORTS MEDICINE & REHABILITATION**
53880 Carmichael Drive • South Bend, IN 46635
60160 Bodnar Boulevard • Mishawaka, IN 46544
(574) 247-9441

AUTHORIZATION FOR PHI USE/DISCLOSURE BY PRACTICE FORM

Patient Name: _____

Health Record No. _____ Date of Birth: _____

Address: _____

Physician: _____

By signing below, I hereby authorize the use or disclosure of the above-named Patient's individually identifiable and protected health information ("PHI") by the above-named Practice for the specific purpose(s) stated below [which do not relate to the day-to-day functions performed by the Practice with regard to my Treatment, Payment and certain Health Care Operations and are not otherwise required or permitted by law]:

**SOUTH BEND ORTHOPAEDIC
SPORTS MEDICINE & REHABILITATION**

**Person/Entity to Receive PHI (Complete
Only If Practice Is To Disclose PHI):**

Person/Entity _____

Address _____

City, State ZIP _____

**INSTRUCTIONS: PATIENT TO "X", DATE AND INITIAL ALL APPLICABLE
SECTIONS BEFORE SIGNING.**

- (1) _____ The type and amount of my PHI to be used or disclosed by the Practice is as follows, subject to any content or time limits listed below:
- | | | |
|--|---|---------------------------|
| _____ Entire Patient Record (or specify below) | | |
| _____ Medication List | _____ Allergy List | _____ Immunization Record |
| _____ Lab Result(s) | _____ Treating/Consulting Physician Reports | |
| _____ Most Recent H&P | _____ Most Recent Discharge Summary | |
| _____ Lab Result(s) | _____ X-ray and Imaging Report | |
| _____ Other | | |

State the particular purpose(s) and any Patient-imposed limitation(s) or expiration date, event or condition(s) or "None," here:

- (2) If my PHI contains information regarding a communicable disease, acquired immunodeficiency syndrome (AIDS) or human immunodeficiency virus (HIV), mental health psychotherapy services, treatment for alcohol and drug abuse or genetic testing information ("Special PHI"), then I hereby authorize the following Special PHI to be disclosed to the above-named Person/Entity for the following purpose(s) { Patient to

check, date, initial and state purpose only if applicable]:

	Purpose(s) of Disclosure to Person/Entity
_____ Communicable Disease	_____
_____ AIDS or HIV Status	_____
_____ Mental Health Services	_____
_____ Drug and Alcohol Treatment	_____
_____ Genetic Testing Information	_____

- (3) I understand that if I do not specify an expiration date, event or condition in (1) above, this Authorization will expire in sixty (60) days (or in the case of PHI concerning mental health services, one hundred and eighty (180) days) from the date this Authorization is signed by the above-listed Patient.
- (4) I understand that the PHI used or disclosed may be subject to redisclosure by the Person/Entity receiving it and no longer protected.
- (5) I understand that my signature on this Authorization is voluntary and my refusal to sign will not affect my ability to receive treatment from the Practice. I understand that I have a right to revoke this Authorization at any time, in a letter addressed to the Practice at the above-listed Practice address, but the revocation will not apply (1) to PHI that has already been released in reliance on this Authorization, or (2) to PHI created by the Practice expressly for disclosure to the above-listed Person/Entity.
- (6) I understand that if I have any questions regarding the use or disclosure of my PHI, I can contact South Bend Orthopaedics, Sports Medicine & Rehabilitation at any time.

Patient or Personal Representative* Signature

Date

(*) If signed by Personal Representative, state relationship to Patient: _____