SOUTH BEND ORTHOPAEDICS
A DIVISION OF ASCENDANT ORTHOPEDIC ALLIANCE, LLC

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AUTHORIZATION FOR PHI USE AND DISCLOSURE FORM

PATIENT INFORMATION

Account Number: _____ Patient Name: _____

Date of Birth: _____ Address: _____

Physician: _____ City, State, Zip: _____

PERSON OR ENTITY TO RECEIVE PHI (IF AUTHORIZING RELEASE):

By signing below, I hereby authorize the use or disclosure of the above-named patients' 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 treatment, payment and certain health care operations that are not otherwise required or permitted by law):

☐ Self

☐ Person/Entity _____
Address _____
City, State, Zip _____

TYPE OF PHI

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 Medical Record
- Specify Below:

☐ Medication List
☐ Lab Result(s)
☐ Most Recent H&P
☐ X-Ray and Imaging Report(s)
☐ Allergy List
☐ Treating/Consulting Physician Report(s)
☐ Most Recent Discharge Summary
☐ Other

- State the expiration date, event or condition(s) or particular purpose(s) and any patient-imposed limitation(s) here:

_____

_____

If my PHI contains information regarding 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).

Initial and Date: (Patient to check, date, initial and state purpose only if applicable)

☐ Communicable Disease _____
☐ AIDS or HIV Status _____
☐ Mental Health Service _____
☐ Drug and Alcohol Treatment _____
☐ Genetic Testing Information _____

- I understand if I do not specify an expiration date, event, or condition in the 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 of this authorization is signed by the above listed patient or personal representative.
- I understand that the PHI used or disclosed may be subject to re-disclosure by the person/entity receiving it and no longer protected.
- 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 I have the above-listed practice address, but the revocation will not apply to; (1) PHI that has already been released in reliance on this authorization, or (2) PHI created by the practice expressly for disclosure to the above-listed person/entity.
- I understand that if I have any questions regarding the use or disclosure of my PHI, I can contact the office at any time.

_____ _____
Signature (Patient or Personal Representative*) Date

(*) If Personal Representative, state relationship to patient _____