Date Received ___________
Initials ___________

AUTHORIZATION TO USE AND/OR DISCLOSE HEALTH INFORMATION

I, [name of patient] ________________________________, authorize **Orthopedic Clinic of Galveston County Associates** to use and/or disclose my health information as identified below to:

Name of Provider: ________________________________

Address: ________________________________

____

Phone Number: ________________________________

Fax Number: ________________________________

For the following purpose(s): **[describe each purpose; if requested by patient, you may state "at patient's request"]**

____

____

By initialing the spaces below, I specifically authorize the use or disclosure of the following health information and/or records, if such information and/or records exist:

_____ All records from ________________ (date) to ________________ (date)

_____ Initial Exam records

_____ All Office Visit notes

_____ All Hospital records (including nursing records, progress notes, and transcribed notes)

_____ Medical records needed for continuity of care

_____ Laboratory/Pathology reports

_____ Diagnostic images and imaging reports

_____ Emergency and urgent care records

_____ Billing/Financial statements

_____ Psychotherapy notes (Authorization for the use and/or disclosure of psychotherapy notes cannot be combined with any other authorization.)

_____ Drug/alcohol diagnosis, treatment, and/or referral information (By Federal law, you must provide a description of what information is to be released. Federal law prohibits the re-disclosure of such information.)

_____ Other ____

(Continued on next page)

Except to the extent that action has already been taken in reliance upon this authorization, I understand that I may revoke this authorization at any time by giving written notice to **Orthopedic Clinic of Galveston County Associates** Unless revoked earlier, this authorization will expire 180 days from the date of signing or upon **[specific date or event]** ______________________.

I understand that I may refuse to sign this authorization and that my refusal to sign will not affect my ability to obtain treatment, payment, enrollment, or eligibility for benefits. I may inspect or copy any information to be used or disclosed under this authorization.

I also understand that, if the person or entity receiving this information is not a health care provider or health plan covered by federal privacy regulations, the information described above may be re-disclosed and no longer protected by these regulations. However, the recipient may be prohibited from disclosing my health information under other applicable state or federal laws and regulations.

I further understand that the person(s) I am authorizing to use or disclose my information may receive compensation (either directly or indirectly) for doing so.

____ ______________________________

Signature of Individual or Individual's Legal Representative Date

____ ______________________________

Print Name or Print Name of Legal Representative Relationship to Individual

Office Use Only:

____ ______________________________

Received by Date

(A copy of this signed form will be provided to the individual and/or the individual's legal representative.)