

Central Texas Pediatric Orthopedics & Scoliosis Surgery

Authorization to Use or Disclose Protected Health Information

Print Name: _____ Date of Birth: ____/____/____ SS#: ____-____-____

Address: _____ Telephone: (____) _____
(street, city, state, zip code)

The following individual or organization is authorized to make the disclosure: Central Texas Pediatric Orthopedics & Scoliosis Surgery
 Other (please specify): _____

This information may be disclosed to and used by the following individual or organization:

Name

Address

City/State/Zip

Fax # (REQUIRED)

Treatment Dates: _____ Purpose of this request: _____

The following information is to be disclosed: (Please check one box for each item)

	Yes	No
Complete Record:	<input type="checkbox"/>	<input type="checkbox"/>
Physician Notes:	<input type="checkbox"/>	<input type="checkbox"/>
Lab Results:	<input type="checkbox"/>	<input type="checkbox"/>
Copy of X-Rays:	<input type="checkbox"/>	<input type="checkbox"/> (additional charge) _____
Other:	<input type="checkbox"/>	<input type="checkbox"/> If other, please specify: _____

Sensitive Information: I understand that the information in my record may include information relating to sexually transmitted diseases, acquired immunodeficiency syndrome (AIDS) or infection with the Human Immunodeficiency Virus (HIV). It may also include information about behavioral or mental health services or treatment for alcohol and drug abuse.

Redisclosure: I understand that any disclosure of information carries with it the potential for redisclosure and that the information then may not be protected by federal confidentiality rules.

Right to Revoke: I understand that I have the right to revoke this authorization at any time. I understand that my revocation must be in writing, and I understand the revocation will not apply to information already released based on this authorization.

Other Rights: a) I understand that authorizing the disclosure of this health information is voluntary and that I may refuse to sign this authorization. I do not need to sign this form to assure treatment. However, if this authorization is needed for participation in a research study, my enrollment in the research study may be denied. b) I understand that I may inspect or obtain a copy of the information to be used or disclosed.

Expiration: Unless otherwise revoked, this authorization will expire on the following date, event or condition: _____.
If I do not specify an expiration date, event or condition, this authorization will expire in six months.

Signature of patient or legal representative:

Date:

If signed by legal representative, relationship to patient: