Bluegrass Orthopaedics Authorization Form

I, ___________________________________, hereby authorize Bluegrass Orthopaedics to use and/or disclose my protected health information described below to____ ____.

My protected health information will be used or disclosed upon request for the following purposes (please name and explain each purpose):____.

This authorization for use and/or disclosure applies to the information described below (mark those that apply):

- ▫ Any and all records in the possession of Bluegrass Orthopaedics including mental health, HIV, and/or substance abuse records. (Cross out any item you do not authorize to be released.)
- ▫ Itemized billing statement
- ▫ Records covering the period of time ______/______/______ to ______/______/______.
- ▫ Records regarding treatment for the following condition or injury _________________ ____ on or about ____.
- ▫ X-Rays
- ▫ MRI
- ▫ CD
- ▫ Other (please specify – include dates): _____________________________________.

I understand that I have the right to revoke this authorization, in writing, at any time by sending such written notification to Manager – Health Information. I also understand that my revocation is not effective to the extent that the persons I have authorized to use and/or disclose my protected health information have acted in reliance upon this authorization.

I understand that I do not have to sign this authorization and that Bluegrass Orthopaedics may not condition treatment or payment on whether I sign this authorization.

I understand that information used or disclosed pursuant to this authorization may be subject to re-disclosure by the recipient and no longer protected by federal laws and regulations regarding the privacy of my protected health information.

This authorization expires one year from the date signed **OR** in the event of ____________________________________.

____   _____/_____/_____
Signature of Patient or Personal Representative   Date

____   ____
Printed Name of Patient or Personal Representative   Description of Personal Representative's Authority

_______________________   _____/_____/_____   _______________________
Acct #   DOB   Social Security #