

Interlakes Orthopaedic Surgery

PATIENT AUTHORIZATION FOR USE AND DISCLOSURE OF PROTECTED HEALTH INFORMATION

1. **Authorization.** By signing this Authorization, I authorize the Practice's Privacy Officer to use and/or disclose to the person or entity named below the protected health information described below ("PHI").

2. **Purpose.** This Authorization is granted for the following purpose(s):

If I have initiated this Authorization and do not wish to indicate the purpose for the use or disclosure of PHI, I may simply state that this Authorization is "at the request of the undersigned." [To choose that option, check here _____.]

3. **Expiration Date/Event.** This Authorization is valid until ____/____/____ or until the following event: _____.

If this Authorization is for use or disclosure of PHI for research, including the creation and maintenance of a research database or research repository, I may indicate an expiration date of "end of research" _____ or "none _____." [Check the one that applies.]

4. **Limitations.** In addition to the above, the following is/are other criteria or limitations that I make regarding this Authorization:

5. **Voluntary Act.** I expressly acknowledge that this Authorization is voluntary.

6. **Pre-conditions.** I understand that the Practice may not condition the provision to me of treatment on my signing this Authorization, except in the following situations:

- (a) if the treatment is research-related only; or
- (b) if the treatment is solely for the purpose of creating PHI to be disclosed to a third party.

I understand that treatment provided for research related purposes only or treatment provided solely to create PHI will not be provided if I do not sign this Authorization.

7. **Research.** I understand that access to PHI that was created or obtained by the Practice in the course of research that includes treatment may be temporarily suspended for so long as the research is in progress, but will be reinstated upon completion of the research. I hereby agree to denial of access to the PHI in that circumstance.

8. **Marketing.** I authorize the Practice to market products and services to me, if the Practice discloses to me whether it receives remuneration from the third party whose product or service is being marketed. The Practice will inform me by checking the following that applies:

remuneration – yes _____ ; remuneration _____ no .

9. **Revocation.** I understand that this Authorization may be revoked by me at any time, provided that I submit a signed revocation form to the Practice's Privacy Officer. However, any revocation shall not apply to the extent that the Practice has taken action in reliance on this Authorization.

10. **Re-disclosure.** I understand that the information used or disclosed pursuant to this Authorization may be re-disclosed by the recipient, and that the information will no longer be protected by the Practice or the HIPAA Privacy Rules.

11. **Copy of Authorization.** If the Practice has requested this Authorization from me, I understand that the Practice will provide me with a copy of this Authorization once signed by me.

Name of Individual (printed)

Signature of Individual

Signature of Personal Representative

Relationship
(e.g., Attorney-In-Fact, Guardian,
Parent if a minor)

Date Signed ____/____/____

Witness: _____

DESCRIPTION OF PHI (also indicate PHI time reference - for example, PHI dated to):

DISCLOSE PHI TO:
