University Orthopedic and Joint Replacement Center
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HIPAA COMPLIANT AUTHORIZATION FOR RELEASE OF PROTECTED HEALTH INFORMATION PURSUANT TO 45 CFR 164.508

Re: Patient name:_____ Date of Birth: _____

I hereby authorize and request the disclosure of my protected health information for the purpose of medical treatment to (provide name, address, phone, fax):

I request that the designated Custodian of Records disclose full and complete protected medical information indlucing the following (check those that apply).

____ medical records from: (date)_____ to (date)_____

____ office notes (except psychotherapy notes) ____ consultation reports ____ operative reports
____ diagnostic test results ____ lab results ____ radiology study results ____ prescriptions

____ reports from other providers ____ other (list records to be released, below)

_____ _____ _____

ACKNOWLEDGMENT OF UNDERSTANDING:

I understand the information to be disclosed may include information related to sexually transmitted diseases, HIV, AIDS, and alcohol and/or drug abuse as per 42 CFR 2.31, the restrictions for which have been specifically considered and expressly waived. I authorize the disclosure of such information. I further understand the following:

a) I have a right to revoke this authorization in writing at any time, except to the extent that information has already been released in reliance upon it;
b) Information released in response to this authorization may be re-disclosed to other parties and federal or state law may not protect any re-disclosure;
c) My treatment or payment for treatment cannot be conditioned on the signing of this authorization;
d) My signing of this authorization is voluntary; I have the right to refuse to sign it
e) This authorization shall be in full force and effect for one (1) year from the date of signing.
f) A facsimile or copy of this authorization shall be as effective as the original.

Signature of patient or legal representative & relationship:_____

_____

Date:_____