

UNIVERSITY ORTHOPAEDIC ASSOCIATES, LLC
AUTHORIZATION FOR USE AND DISCLOSURE OF
PROTECTED HEALTH INFORMATION

Patient's Name: _____ **SSN:** _____

I hereby authorize the use and disclosure of individually identifiable health information relating to me as described below:

Category of PHI

Medical/Surgical Records	Claims/Billing Information	Mental Health Records
Drug/Alcohol Abuse	HIV Test Results	Genetic Test Results
Radiology Films		

The above information will be called "PHI" throughout the rest of this form.

Persons or Entities Authorized to Make Use of or Disclose PHI:

UNIVERSITY ORTHOPAEDIC ASSOCIATES, LLC

Persons or Entities Authorized to Receive or Make Use of PHI: (enter name and address)

I authorize my PHI to be used and/or disclosed for the following purposes:

At my request

For _____ [SPECIFY PURPOSE]

For CLINICAL TRIAL: I understand that University Orthopaedic Associates, LLC may refuse provision of research-related treatment unless I sign an authorization for use and disclosure of my PHI for the research. I understand that I will not have access to my PHI while the clinical study is open, but will be provided access when the study is closed.

For MARKETING: I understand that University Orthopaedic Associates, LLC may receive monetary compensation from the party receiving my PHI or that party's affiliates.

I understand that if the person or entity receiving Authorized Information is not a health plan or health care provider covered by federal privacy regulations, the authorized information may be re-disclosed by the recipient and may no longer be protected by federal or state law.

I understand that I may revoke this authorization at any time by requesting a Revocation of Authorization form from University Orthopaedic Associates, LLC. However, if I choose to do so, I understand that my revocation will not affect any actions taken by University Orthopaedic Associates, LLC before receiving my revocation.

This authorization expires at the earlier of _____ OR the date the following

Event occurs: _____
[Describe event or write "not applicable"]

Signature of Patient or Patient's Personal Representative: _____

Date: _____

For Personal Representative of the Patient (if applicable):

Print Name of Personal Representative: _____

Parent, guardian or caregiver of a minor patient.

Guardian or conservator of an incompetent patient

Executor of estate of a deceased patient.

Other _____ [SPECIFY RELATIONSHIP]