Authorization For Use And Disclosure Of Protected Health Information

UOA
University Orthopaedic Associates
A DIVISION OF ORTHO ALLIANCE NJ

Patient Name: _____ Date of Birth: _____

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

☐ Radiology Films (including outside films not rendered in the facility) X-ray # _____

or description of outside 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 Associate, 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.

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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"

Print Name: _____ **Phone Number:** _____

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, identification must be provided.
- ☐ Spouse, identification must be provided.
- ☐ Guardian or conservator of an incompetent patient, identification and documentation must be provided.
- ☐ Executor of estate of a deceased patient, identification and documentation must be provided.
- ☐ Other: _____

Specify Relationship

Print Name: _____ **Phone Number:** _____

Signature of Representative: _____

Date: _____