ORTHOPEDIC ASSOCIATES SURGERY CENTER
PATIENT AUTHORIZATION FOR RELEASE OF INFORMATION

YOU MAY REFUSE TO SIGN THIS AUTHORIZATION

I hereby authorize the use or disclosure of my individually identifiable health information as described below. I understand that this authorization is voluntary. I understand that if my health information is used or disclosed, the released information may no longer be protected by privacy regulations issued by the federal government.

Patient Name: _____
Social Security Number: _____

Persons authorized to use or disclose the information:

_____
_____

Persons authorized to receive the information:

_____
_____

Specific description of information (including date[s]):

_____
_____

Orthopedic Associates Surgery Center must complete the following if they are requesting the disclosure:

a. What is the purpose of the use or disclosure?

_____
_____

b. Will Orthopedic Associates Surgery Center receive financial or in-kind compensation in exchange for using or disclosing the health information described above? ☐ Yes ☐ No

The patient or patient's representative must read and initial the following statements:

a. I understand that my health care and payment for my health care will not be affected if I do not sign this form. **Initials: _____**
b. I understand that I may see and copy the information described on this form if I ask for it, and that **Orthopedic Associates Surgery Center** will give me a copy of this form after I sign it. **Initials: _____**
c. I understand that this authorization will expire on ____/____/____. **Initials: _____**
d. I understand that I may revoke this authorization at any time by notifying **Orthopedic Associates Surgery Center** in writing, but if I do revoke it, the revocation will not have any effect on any actions Orthopedic Associates Surgery Center took before it received the revocation. **Initials: _____**

_____ _____
Signature of Patient or Patient's Representative Date

Printed Name of Patient's Representative: _____
Relationship to Patient: _____