

Authorization for Use and Disclosure of Protected Health Information (PHI)

Plano Orthopedic Sports Medicine & Spine Center, P.A.

5228 W. Plano Parkway, Plano, TX 75093

Phone 972-250-5700 Fax 972-250-5748

Patient Legal Name _____	Birth Date: _____	Social Security No. _____
Address _____		Telephone No. _____
City _____	State _____	Zip Code _____
I hereby authorize: <u>Plano Orthopedic Sports Medicine and Spine Center, P.A.</u> <i>Facility or Covered Entity</i>		
To disclose medical record information and/or protected health information of the patient listed above to:		

<i>Name / Title</i>		

<i>Address</i>		
Purpose: _____		
For treatment date: _____		
Type of Access Requested:	Selected Portions of PHI:	
<input type="checkbox"/> Copies of the record	<input type="checkbox"/> Emergency Room	<input type="checkbox"/> Lab
	<input type="checkbox"/> History & Physical	<input type="checkbox"/> Radiology Reports
	<input type="checkbox"/> Consult Report	<input type="checkbox"/> Radiology FILMS
	<input type="checkbox"/> Operative Report	<input type="checkbox"/> Path Report
<input type="checkbox"/> View In house record	<input type="checkbox"/> Discharge Summary	<input type="checkbox"/> Face Sheet
		<input type="checkbox"/> Medication Record
		<input type="checkbox"/> Out patient Rehab
		<input type="checkbox"/> Progress Notes
		<input type="checkbox"/> Physician Orders
		<input type="checkbox"/> Entire Record
		<input type="checkbox"/> Other _____
I acknowledge, and hereby consent to such, that the released information may _____ contain alcohol, drug abuse, psychiatric, HIV testing, HIV results or AIDS information.		
<i>Initials</i>		
Expiration: This authorization shall expire on the 180 th day after it is signed, unless as provided otherwise upon Expiration Date or Event given here:		
I understand that:		
1. This authorization may be revoked by me at any time except to the extent that action has been taken in reliance upon it.		
2. Treatment and payment may not be conditioned on obtaining this authorization.		
3. The information used or disclosed pursuant to the authorization may be subject to redisclosure by the recipient and no longer protected.		
4. Fees/charges will comply with all laws and regulations applicable to release of information.		
5. I get a copy of this form after I sign it.		
I have read the above and authorize the disclosure of the protected health information as stated.		
_____	_____	_____
Date	Signature of Patient/Parent/Patient Representative	Relationship to Patient

Address and telephone number of Requestor (if different from patient information)		

Original – facility

Copy – individual (pt or pt rep)