Voytik Center for Orthopedic Care
2700 Westside Drive NW; Suite 301
Cleveland, Tennessee 37312
Phone: (423) 479-3600
Fax: (423) 303-1234

AUTHORIZATION TO DISCLOSE PROTECTED HEALTH INFORMATION

Release information FROM:

Organization Name: _____

Address: _____

_____

Release information TO:

Organization Name: _____

Address: _____

_____

By signing this Authorization, I authorize my Health Care Provider to disclose my protect health information. IDENTIFYING INFORMATION AT THE TIME OF SERVICE

Patient's Full Name _____

Maiden or Other Name _____

Date of Birth _____/_____/_____ **SSN/Medical Record #** _____

Full Address

_____

Covering the period(s) of health care: **FROM** _____/_____/_____ **TO** _____/_____/_____

1. **Information authorized for disclosure**, *if included in my records: (CHECK ALL THAT APPLY)*

   _____ Complete Health Record

   _____ Visit/Discharge Summary

   _____ Clinical Documentation of Physical

   _____ Documentation of Consultation

   _____ Immunization Records

   _____ Progress Reports

   _____ Radiology and Diagnostic Imaging Reports

   _____ Photographs, Videos, Digital, or Other Images

   _____ Pathology Reports

   _____ Laboratory tests (please specify): _____

   _____Other (please specify): _____

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2. **If applicable, I also give permission** for the following "Sensitive Protected Health Information" to be disclosed (***please initial below***): *CHECK ALL THAT APPLY*

   _____Acquired Immunodeficiency Syndrome (AIDS) or Infection with Human Immunodeficiency Virus (HIV)

   _____Behavioral Health Services/Psychiatric Care

   _____Treatment for Alcohol and/or Drug Abuse

   _____Sexually Transmitted Diseases (STD)

   _____Genetic Counseling/Testing

   _____ ***(initial)*** *I understand that the information disclosed pursuant to this Authorization,* ***EXCEPT*** *information protected by Federal and/or State regulations about confidentiality of drug and alcohol abuse records, HIV and Mental Health, may be subject to re-disclosure by the recipient and no longer protected by federal privacy regulations or other applicable state and federal laws.*

3. **The purpose for which disclosure is authorized** *(check where applicable):*

   _____ Medical Care _____ Insurance _____ Benefit eligibility _____Immunization

   Other: _____

4. **I understand** that I have a right to revoke this authorization at any time. **I understand** that if I revoke this authorization I must do so in writing and present my written revocation to the provider(s) of care. **I understand** that the revocation will not apply to information that has already been released in response to this authorization. **I understand** that the revocation will not apply to my insurance company when the law provides my insurer with the right to review or contest a claim. Unless otherwise revoked, this authorization will expire on the following date, event, or condition: (Date) _____/_____/_____ or UNLIMITED. **If I fail to specify an expiration date, event, or condition, this authorization will expire in exactly one year from the date of signage. If this authorization pertains to oneself as the patient, the expiration date can be documented as unlimited. If documented as such, (Initial here _____) it is the responsibility of individual to notify the practice of any life changes, i.e. guardianship, so that appropriate documentation is given for the change.**

5. **I understand** that any disclosure of healthcare information carries with it the potential for unauthorized and future re-disclosures, as allowed by HIPAA and other federal privacy rules. If I have questions about disclosures of my health information, I can contact my provider of care.

6. This facility, its employees, officers, and physicians are hereby released from any legal responsibility or liability for disclosure of the above information to the extent indicated and authorized herein.

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Signed:

Patient – (or Legal Representative, Parent or Legal Guardian) *(Relationship if not Patient)*

ID Provided: _____ *Date* _____/_____/_____

OFFICIAL USE ONLY

Name/Title of Person Releasing Information: _____ Date ____/_____/_____