PINNACLE
SPORTS MEDICINE & ORTHOPAEDICS

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AUTHORIZATION FOR THE USE AND DISCLOSURE OF PROTECTED HEALTH INFORMATION

Patient Name: _____ Date of Birth: _____ SSN: _____

Address: _____ City: _____ State/Zip: _____

I authorize the use or disclosure of the above named individual's health information as described below:

The following individual or organization is authorized to make the disclosure:

Provider or Facility: **PINNACLE SPORTS MEDICINE & ORTHOPAEDICS**

Address: **1818 E. 23RD AVENUE** City: **HUTCHINSON** State/Zip: **KS 67502**

The information to be disclosed is as follows (please check the information you want released):

☐	History & Physical Exam/Office Notes	☐	Laboratory Report(s)
☐	X-ray Reports/films	☐	Operative Report(s)
☐	MRI Report/films	☐	Complete Health Records From: _____To: _____
☐	Pathology Report(s)	☐	Other:

Treatment Date(s): _____ (Please list date range or specific date of service)

Purpose of Disclosure: ☐ Share information with other providers involved in my care. ☐ Transfer of care ☐ Personal use/copy

☐ Ongoing access to information when requested ☐ Other: _____

I specifically authorize the release of types of information **INITIALED** below:

☐	Alcohol and drug abuse treatment	☐	HIV Status or AIDS
☐	Mental Health	☐	Genetic Information

This information may be disclosed to and used by the following individual or organization:

Name:_____

Address: _____ City: _____ State/Zip: _____

Phone Number: _____ Fax Number: _____

I understand this authorization may be revoked in writing at any time except to the extent already acted upon. To revoke this authorization I must send a request in writing to: Human Resources, HIPAA Privacy Officer, at Pinnacle Sports Medicine & Orthopaedics, P.A. This authorization expires on _____ (date or event) or within one (1) year of the date signed if I have not provided an expiration date or event. I understand that treatment, payment, enrollment or eligibility for benefits may not be conditioned on signing this authorization.

I authorize the release of my records relating to: (check one):

☐ Treatment rendered **prior** to the date this authorization is signed

☐ Treatment rendered **both before and after** the date this authorization is signed

☐ Treatment rendered **only after** the date this authorization is signed

I understand that my information used or disclosed pursuant to this authorization may be redisclosed by the recipient and may no longer be protected by the Privacy Regulations. A photo static copy of this authorization shall be considered as effective and valid as the original authorization. I also understand fees may be charged for preparing and sending copies of records including charge for labor and supplies up to $18.97 per request and a copying charge of up to $0.63 for the first 250 pages and $0.45 for additional pages (K.S.A 65-4971(b)).

_____ _____ _____

Signature of Patient or Personal Representative **Printed Name** **Date**

If Personal Representative, Relationship to Patient: _____

The information disclosed to you may be from records protected by Federal confidentiality rules (42 CFR Part 2). The Federal rules and state law prohibit you from making any further disclosure of this information unless further disclosure is expressly permitted by the written consent of the person to whom it pertains or as otherwise permitted by 42 CFR Part 2. A general authorization for the release of medical or other information is NOT sufficient for this purpose. The Federal rules restrict any use of the information to criminally investigate or prosecute any alcohol or drug abuse patient.

For Office Use Only: Records sent _____, 20___, By: _____
(Date) (Initials)