alabama orthopaedic surgeons

52 MEDICAL PARK EAST DRIVE, SUITE 220
BIRMINGHAM, AL 35235
P: 205.838.4747
F: 205.838.2712 / 205.838.4510

AlabamaOrthopaedicSurgeons.com

Dr. Donald Slappey Dr. Spain Hodges Dr. Jason Cobb
Dr. Timothy Cool Dr. Jerry Ambrosia

AUTHORIZATION FOR USE AND DISCLOSURE OF PROTECTED HEALTH INFORMATION

Patient Name:_____ Date of Birth:_____

Patient Address:_____ SSN:_____

_____

By signing below, you hereby authorize us to use or disclose information about yourself(or another person for whom you have the authority to sign) that is protected under federal law, for the sole purpose and time period described below. You may refuse to sign this authorization. Subject to certain exceptions, you have the right to inspect and copy the protected health information.

Information to be used or disclosed (must be identified in a specific and meaningful fashion); and purpose of the use and disclosure (*if Authorization requested by the patient put: "At the request of the individual!"*)

_____

_____

Disclose the following Health Information: *(include dates of service, i.e., appointment dated. type of service, etc)*

_____

_____

Disclose the above Health Information to: (The name or other specific identification of the person(s), or class of persons, to whom the Practice *may make the requested use or disclosure)*

_____

_____

_____

_____

Expiration date or an expiration event (must relate to the individual or the purpose of the use or disclosure):

_____

_____

This information about you is protected under federal law, and you have the right to revoke this authorization in writing. Please be advised; however that any revocation will be effective only to the extent we have not already taken action in reliance on your authorization. By signing below, you recognize that the protected health information used or disclosed pursuant to this authorization may be subject to re-disclosure by the recipient of this disclosure and may no longer be protected under federal law. We will not condition treatment based on your authorization. You may refuse to sign the authorization.

_____ _____

Patient Signature or Personal Representative Date