AUTHORIZATION FOR USE AND DISCLOSURE OF PROTECTED HEALTH INFORMATION TO LOUISVILLE ORTHOPAEDIC CLINIC

I, ____________________________, hereby authorize Louisville Orthopaedic Clinic, PSC to use and/or disclose my protected health information described below to:

Requestor:

- ☐ Patient
- ☐ Release to ____

My protected health information will be used or disclosed upon request for the following purposes:

- ☐ **Patient** wants copy to use at their discretion.
- ☐ **Insurance** (Personal, Workers' Compensation, or Disability)
- ☐ **Accident** claim
- ☐ **Other** (Please specify and include dates) ____________________________

This information for use and/or disclosure applies to the information described below:
(Mark those that apply, all or specific injuries or dates of service)

- ☐ **Any and all records** in the possession of Louisville Orthopaedic Clinic, PSC, 4130 Dutchmans Lane, Suite 300, Louisville, KY 40207, including mental health, HIV and/or substance abuse records.
- ☐ Records regarding **treatment for the following condition or injury**: ____________________ **Date of treatment**: ______________
- ☐ Records covering the **period of time** ___________ to ________
- ☐ **Other** (*please specify and include dates*): ____

I understand that I have the right to revoke this authorization at any time by sending such written notification to Louisville Orthopaedic Clinic, PSC, 4130 Dutchmans Lane, Suite 300, Louisville, KY 40207. I also understand that my revocation is not effective to the extent that the persons I have authorized to use and/or disclose my protected health information have acted in reliance upon this authorization.

This authorization **expires** on (*Please specify a date or event)*:_________________________
If expiration is blank, authorization will remain valid for 2 years from the date of the signature.

I understand that I do not have to sign this authorization and that Louisville Orthopaedic Clinic, PSC may not deny treatment or payment on whether I sign this authorization, but release of information to outside entities other than for billing or treatment purposes will not be made.
I understand that information used or disclosed pursuant to this authorization may be subject to re-disclosure by the recipient and may no longer be protected by federal laws and regulations regarding privacy of my protected health information.

____ ___________ ____________
Signature of Patient or Personal Representative Date of Birth Today's Date

______________________________________ __________________________________
Printed name of Patient or Personal Representative Description of Personal Rep's Authority

Revised 11/30/09