



Authorization Form

I, _____, hereby authorize Bluegrass Orthopaedics & Hand Care to use and/or disclose my protected health information described below to _____.

My protected health information will be used or disclosed upon request for the following purposes (please name and explain each purpose):

This authorization for use and/or disclosure applies to the information described below (mark those that apply):

- Any and all records in the possession of Bluegrass Orthopaedics & Hand Care including mental health, HIV, and/or substance abuse records. (Cross out any item you do not authorize to be released.)
- Itemized Billing Statement
- Records covering the period of time _____ to _____
- Records regarding treatment for the following condition or injury _____

_____ on or about _____

- X-Rays
- MRI
- CD
- Other (please specify and include dates)

I understand that I have the right to revoke this authorization, in writing, at any time by sending such written notification to Manager – Health Information. 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.

I understand that I do not have to sign this authorization and that Bluegrass Orthopaedics & Hand Care may not condition treatment or payment on whether I sign this authorization.

I understand that information used or disclosed pursuant to this authorization may be subject to re-disclosure by the recipient and no longer protected by federal laws and regulations regarding the privacy of my protected health information.

This authorization expires on (please list a specific date or event) _____.

I certify that I have received a copy of this authorization.

Signature of Patient or Personal Representative Date

Printed Name of Patient or Personal Representative Description of Personal Representative's Authority

Account # Date of Birth Social Security #