

**3B ORTHOPAEDICS, P.C.
AUTHORIZATION TO USE OR
DISCLOSE PROTECTED HEALTH INFORMATION**

I hereby authorize the use or disclosure of protected health information (as defined by 45 C.F.R. § 164.501) about me, by or to the persons or entity, and upon the terms and conditions, set forth below. I understand that this authorization is voluntary.

All Items Must Be Completed

Patient Name: _____

Patient Address: _____

Phone Number: _____ Date of Birth: _____

Last 4 digits of Social Security #: _____

1. Person(s) or class of persons authorized to make the requested use or disclosure of the information: _____ 3B Orthopaedics, P.C. staff

2. Person(s) or class of persons authorized to receive the information:

3. Description of information that may be used or disclosed:

- ___ 3B Physician's Notes
- ___ Other Physicians Correspondence/Notes
- ___ Pathology Reports
- ___ Radiology Reports(MRI, Bone Scan, Xray)
- ___ Operative notes and Discharge Summary
- Date of Service _____
- ___ Rehab Notes
- ___ Radiographic Films (separate release required)
- ___ All of the Above

4. Period requested: From _____ to _____

(Complete Both Sides>>>)

5. The information will be used or disclosed for each of the following purposes:
(Note: the statement "at the request of the individual" is a sufficient description of the purpose when an individual initiates the authorization and does not, or elects not to, provide a statement of the purpose).

6. I understand that the information used or disclosed pursuant to this authorization may be disclosed by the recipient and may no longer be protected by federal privacy regulations.

7. I understand that I may refuse to sign this authorization and that my refusal to sign will not affect my ability to obtain treatment or payment or my eligibility for benefits. Additionally, I understand, however, that the provision of research-related treatment may be conditioned on my signing this authorization for the use and disclosure of protected health information created for such research.

8. I understand that I may revoke this authorization in writing at any time by sending such written notification to the Privacy Officer at 3B Orthopaedics, PC, 800 Spruce Street, Philadelphia, PA 19107, except to the extent that this authorization was obtained as a condition of obtaining insurance coverage or action has been taken in reliance on this authorization.

This authorization expires _____ (Note: insert applicable expiration date or expiration event/purpose for use or disclosure).

Signature of Patient or *Personal Representative

Date

Name of Patient's Personal Representative

Relationship to Patient

*** Please provide a description of Representative's authority to act on behalf of patient:

(A copy of this signed authorization form will be provided to the patient)