Name:
Chart:
Date:

OZARK ORTHOPAEDICS

Patient Authorization to Obtain Protected Health Information

By signing this authorization, I authorize Ozark Orthopaedics to obtain certain protected health information (PHI) about me, from the following
(Name and address)

_____

_____

This information will be used for the following purpose:

_____

This authorization will expire on: _____

I do not have to sign this authorization in order to receive treatment from Ozark Orthopaedics. In fact, I have the right to refuse to sign this authorization. When my information is used or disclosed pursuant to this authorization, it may be subject to redisclosure by the recipient and may no longer be protected by the federal HIPAA Privacy Rule. I have the right to revoke this authorization in writing except to the extent that the practice has acted in reliance upon this authorization.

My written revocation must be disclosed for the following purpose:

☐ **Ozark Orthopaedics**
3317 N. Wimberly
Fayetteville, AR 72703
Fax 479-444-6942

☐ **Ozark Orthopaedics**
603-2 N Progress Ave #600
Siloam Springs, AR 72761
Fax 479-549-3733

Signed by: _____ Dated: _____
Signature of Patient or Guardian

_____ _____
Printed name of patient Date of Birth