Name: **Lname, Fname**
Chart: **/SharedID**
Date: **3/2/2016**

TO OBTAIN RECORDS FROM OZARK ORTHOPAEDICS

PATIENT AUTHORIZATION FOR USE AND DISCLOSURE OF PROTECTEO HEALTH INFORMATION

If you would like to authorize Ozark Orthopaedics to release Information to a Family member, Spouse, Physician, personal representative or any other persons not listed, please list their names below:

_____

_____

_____

This authorization permits Ozark Orthopaedics to use and/or disclose the following individually identifiable health Information about me (specifically describe the information to be used or disclosed, such es date(s) of services, level of detail to be released, origin of information, etc.):

_____

Any additional notes/Information: _____

_____

This authorization will expire on: One year from signature date unless otherwise noted.

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 submitted to the Privacy Dfficer at:

☐ **Ozark Orthopaedics**
3317 N. Wimberly
Fayetteville, AR 72703
479-443-7862 Fax

☐ **Ozark Orthopaedics**
603-2 N Progress #600
Siloam Springs, AR 72761
479-443-7862 Fax

Signed by: _____ _____

Signature of Patient or Guardian | Relationship to Patient

_____ _____

Patient's Name | Date of Birth

_____ _____

Print Name of Patient or Legal Guardian | Date