Ozark Orthopaedics
Specializing in You

Limited Patient Authorization for Disclosure of Protected Health Information (PHI)
Please print all information. Form must be signed and dated.

Patient Name: _____

SSN (last 4 digits): _____ **Date of Birth:** _____

Entity Requested to Release Information: _____

Purpose of Request (who will be authorized to receive information) – I authorize the entity identified above to disclose or provide protected health information about me to the individual/entity listed below.

Who will be authorized to receive information (the individual/entity that is to **receive** your PHI):

Individual/Entity Name:_____

Address:_____

Phone/Fax:_____ / _____

Description of information to be disclosed -

___ Entire patient record; **OR** check **ONLY** those items of the record to be disclosed:

___Office Notes ___Home Health/other physician records

___Lab/Pathology reports ___Operative Notes

___X-Rays/MRI/Radiology ___ Other (Please specify):_____

___Billing records (previous 3 years only) Date range: _____

Purpose of disclosure (please record the purpose of the disclosure or check patient request):

___ Patient Request ___Other (please specify):_____

- This authorization will expire one year from the date signed unless you specify an earlier termination. You must submit a new authorization form after the expiration date to continue the authorization. Please list the date of expiration if earlier than one year from date signed:_____
- You have the right to terminate this authorization at any time by submitting a written request to our Privacy Manager. Termination of this authorization will be effective upon written notice, except where a disclosure has already been made based on prior authorization.
- The practice places no condition to sign this authorization on delivery of healthcare or treatment.
- We have no control over the person(s) you have listed to receive your PHI. Therefore, your PHI disclosed under this authorization may no longer be protected by the requirements of the Privacy Rule, and will no longer be the responsibility of the practice.

_____ _____

PATIENT OR AUTHORIZED REPRESENTATIVE SIGNATURE **DATE**

You have the right to receive a copy of signed authorizations upon request

Mail completed form to: Ozark Orthopaedics, Medical Records, 3317 N Wimberly Dr., Fayetteville, AR 72703
Or, fax completed form to: 479-521-4603

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Patient Instructions for Form 7.31

Limited Patient Authorization for Disclosure of Protected Health Information

This form will give our office the authority to provide your protected heath information (PHI) to the person or entity designated on the form, the Limited Patient Authorization limits us to disclose only the information that you designate, and does not give any other rights to the person you have named on the form.

The following outline will describe the information we will need on the form and its purpose. Please address any questions you have with our staff.

Patient Name - Print your name.

Social Security Number and Date of Birth – This information is needed for identity verification and will be maintained in a confidential manner at all times.

Entity Requested to Release Information – This simply identifies who is to provide the information (i.e., our practice).

Purpose of Request - To disclose your protected health information to an individual or entity.

Who will be authorized to receive information – Enter the name, address, phone and fax number of the individual or entity that you are designating to receive disclosure. This section must be completed. We will not process requests without this information**.**

Description of Information to be disclosed –The type and amount of health information that we disclose is determined by you. We can disclose or provide access to all of your health information, or it can be limited to a specific item.

Purpose of Disclosure – Check Patient Request if you are initiating the authorization. Otherwise, the purpose should be stated for you.

Expiration of Termination – This authorization will expire one calendar year from the date signed unless you specify an earlier termination. The authorization would need to be renewed annually as a means of protecting your information by verifying your wish to continue the authorization.

Right to Revoke or Terminate – You may revoke or terminate the authorization at any time by submitting a written notice to our Privacy Manager.

Non-Conditioning Statement - This simply states that our practice does not place conditions for treatment on completion of this authorization form.

Redisclosure Statement – We cannot be responsible for what the receiving entity does with your health information that we provide under this authorization. The redisclosure statement simply informs you of this situation.

Signature and Date – We will need your signature and date of the signature to make the authorization effective.

Copies – We will provide you with a copy of this signed authorization upon request.

Return form to: Ozark Orthopaedics, 3317 N Wimberly Dr., Fayetteville, AR 72703 or, fax to 479-521-4603