Southern Orthopaedic Specialists

Authorization for Release of Protected health Information

Patient's Full Name	**Patient's Social Security Number/Medical Record Number**
Address	**Patient's Date of Birth**
City, State & Zip Code	**Patient's Telephone Number**

I hereby authorize use or disclosure of protected health information about me as described below:

1. The following specific person/class of person/facility is authorized to use of disclose information about me:
   _____

2. The following person (or class of persons) may receive disclosure of protected heath information about me:
   _____
   His / Her / Facility Name
   _____
   Address (to send records to)
   _____
   City, State & Zip Code

3. The specific information that should be disclosed is (please give dates of service if possible):
   _____
   _____
   _____

Drug and/or Alcohol Abuse, and/or Psychiatric, and/or HIV/AIDS Records Release

I understand if my medical or billing record contains information in reference to drug and/or alcohol abuse, psychiatric care, sexually transmitted disease, hepatitis B or C testing, HIV/AIDS (Human Immunodeficiency Virus/Acquired Immunodeficiency Syndrome) testing and/or treatment and/or other sensitive information, I agree to its release.

Check One: _____ ***Yes*** _____ ***No***

Right to Revoke Authorization

Except to the extent that action has already been taken in reliance on this authorization, the authorization may be revoked at any time by submitting a written notice to **Southern Orthopaedic Specialist** at **2731** Napoleon Avenue, New Orleans, LA 70115**.**
Unless revoked, this authorization will expire on the following date, or after the following time period or event_____.

Re-Disclosure

I understand the information disclosed by this authorization may be subject to re-disclosure by the recipient and no longer be protected by the Health Insurance Portability and Accountability Act of 1996.

Signature of Patient or Personal Representative Who May Request Disclosure

I understand that I do not have to sign this authorization, and my treatment or payment for services will not be denied if I do not sign this form. However, if health care services are being provided to me for the purpose of providing information to a third-party (e.g. fitness-for-work test), I understand that services may be denied if I do not authorize the release of information related to such health care services to the third-party. I can inspect or copy the protected health information to be used or disclosed. **I hereby release and discharge Southern Orthopaedic Specialists of any liability and the undersigned will hold Southern Orthopaedic Specialists harmless for complying with this Authorization.**

Signature_____ Date_____

Description of relationship if not patient _____

ALL BLANKS MUST BE COMPLETED. YOU MAY FAX TO (504) 899-7317.