

**Orthopedic Physician Associates, a division of Proliance Surgeons, Inc., P.S., 601
Broadway, Seattle, WA 98122
Fax: 206-622-1644 Telephone: 206-386-2600**

Authorization for Proliance Surgeons, Inc., P.S. To Use or Disclose My Health Care Information

Patient Name: _____ Date of birth: _____
Patient Telephone #: _____ Social Security Number _____

I. My Authorization

You may use or disclose the following health care information (check all that apply):

- All health care information in my medical record
- Health care information in my medical record relating to the following treatment or condition: _____
- Health care information in my medical record for the date(s): _____
- Other (e.g., X rays, bills), specify date(s): _____

You may use or disclose health care information regarding testing, diagnosis, and treatment for (check all that apply):

- HIV (AIDS virus)
- Sexually transmitted diseases
- Psychiatric disorders/mental health
- Drug and/or alcohol use

You may disclose this information to:

Name (or title) and organization: _____
Tel # of recipient _____ Address: _____
City: _____ State: _____ Zip Code: _____

Reason(s) for this authorization (check all that apply):

- At my request Other (Specify) _____
- Check only if practice requests the authorization for marketing purposes
- Check only if practice will be paid or get something of value for providing health information for marketing purposes

This authorization ends 90 days after signing. Indicate if authorization needs to end sooner:

- on date: _____
- When the following event occurs: _____

II. My Rights

I understand I do not have to sign this authorization in order to get health care benefits (treatment, payment, or enrollment.) However, I do have to sign an authorization form:

- To take part in a research study or,
- To receive health care when the purpose is to create health care information for a third party.

I may revoke this authorization in writing. If I do, it will not affect any actions already taken by Proliance Surgeons, Inc., P.S. based upon this authorization. I may not be able to revoke this authorization if its purpose was to obtain insurance. Two ways to revoke this authorization are:

- Fill out a revocation form. A form is available from the practice, or
- Write a letter to the practice.

Once health care information is disclosed, the person or organization that receives it may re-disclose it. Privacy laws may no longer protect it.

Patient or legally authorized individual signature

Date

Printed Name if signed on behalf of the patient

Relationship (parent, legal guardian,
personal representative)