TO: ADVANCED ORTHOPAEDICS
AUTHORIZATION TO DISCLOSE HEALTH INFORMATION

• Federal law says that medical providers cannot share your health information without your permission except in certain situations. If you sign this form, you are giving our office permission to share your health information that our office has with the person you indicate below.
• This authorization is voluntary.
• Right to revoke: If you decide you do not want our office to share your health information any longer, sign the revocation at the end of this form and give this form to our office.
• Payment, enrollment or eligibility for benefits for your health care will not be affected if you do not sign this authorization, unless the disclosure is for eligibility or enrollment determinations, or for risk determinations.
• Our office cannot promise that the person you permit us to share your health information with will not share your health information with someone else you may not want to have your health information.
• You can keep a copy of this authorization, and can contact our officer to get a copy if you do not have one.

My name (print) _____

Date of Birth: _____ Social Security Number: _____

I give permission to: Advanced Orthopaedics to share my health information with:

_____ Relationship _____

_____ Relationship _____

_____ Relationship _____

so that this person or entity may assist me with my health care issues.

Signature of the patient:

_____

Date:_____