Premier Orthopedics, PC

2405 Osler Court, Albany, GA 31707, (229)435-1458, Fax (229) 317-2342,
1107 South Greer Street, Cordele, GA 31709, (229) 273-1730 Fax (229) 273-6732

Patient Authorization for Use and/or Disclosure of Protected Health Information

Patient Name:		Pt Account #:
Address:		
Social Security Number:	Date of Birth:	Contact #:

I hereby authorize Premier Orthopedics, PC to use, release and/or receive my health information as follows:

☐ **Use** the following health information maintained by Premier Orthopedics, PC

☐ **Release** the following health information to: ____

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☐ **Receive** the following health information from: ____

Please select the items that apply to this request:

☐ Clinic or Office Notes

☐ Hospital Admission and/or Discharge Notes

☐ X-Ray Images

☐ MRI Images

☐ Emergency Room Notes

☐ Disability Forms

☐ All Records on File

☐ Other ________________________________

Last surgery date: ______________________ (to be completed by Premier Staff)

By providing this Authorization, I understand as follows:

1. I understand that this Authorization is voluntary. I may refuse to sign this Authorization and my treatment and/or payment obligations will not be affected.
2. I understand that the health information to be released may be subject to re-disclosure by the recipient of the health information and no longer protected by the federal Privacy Rules.
3. I understand that I may revoke this Authorization at any time by notifying Premier Orthopedics, PC in writing, but if I do, it will not have any effect on uses or disclosures prior to the receipt of the revocation.
4. I understand that I will receive a copy of this Authorization form after I sign it.
5. I understand and agree to be financially responsible for any fees associated with this records request and that such fees must be paid prior to the release of records.
6. I understand that this Authorization will terminate one year from the date of my signature unless a different date or expiration date is stated. Specific date: ______________________

____
Signature of Patient or Patient's Representative

____
Date

____
Printed Name of Patient's Representative (*if applicable*)

____
Representative's Relationship to Patient
(if applicable)