AUTHORIZATION FOR THE DISCLOSURE OF INFORMATION TO FACILITY BY ANOTHER ENTITY

I, ______________________________ hereby authorize(s) Scotland Orthopedics, PA to disclose copies of my medical record (Protected Health Information) to ______________ ______________________________ for the following purpose(s): ______________________________ ______________________________.

Patient hereby acknowledges that he/she understands that treatment, payment, enrollment in the health plan, or eligibility for benefits is not conditioned on his/her signing of this Authorization. However, the facility may condition the provision of health care that is solely for the purpose of creating protected health information on Patient's signing of this Authorization, and Facility may condition the provision of research-related treatment on Patient's signing of this Authorization for the use and disclosure of protected health information created for research that includes treatment of the individual.
Patient may refuse to sign this Authorization if he/she so chooses.

The Facility may use or disclose such protected health information only until (expiration date or expiration event relating to the individual or purpose of the use or disclosure).

At all times, Patient retains the right to revoke this Authorization, except if the Authorization was obtained as a condition of obtaining insurance coverage. Such revocation must be submitted to the Facility in writing. The revocation shall be effective *except* to the extent that the Facility has already used or disclosed information in reliance on the Authorization. Patient may remove this Authorization by (describe how Patient may revoke; e.g., where to send a written notice).

Patient has been informed and understands that information used or disclosed pursuant to this Authorization may be subject to redisclosure by the recipient of such information, and, at that point, the information may no longer be protected under the terms of this agreement.

I HAVE READ AND UNDERSTAND THIS INFORMATION. I HAVE RECEIVED A COPY OF THIS FORM AND I AM THE PATIENT OR AM AUTHORIZED TO ACT ON BEHALF OF THE PATIENT TO SIGN THIS DOCUMENT VERIFYING AUTHORIZATION FOR THE USE OR DISCLOSURE THE PROTECTED HEALTH INFORMATION UNDER THE ABOVE STATED TERMS.

Date:__________ Time________AM/PM

____
Signature of Patient

____
Please print name

____
Signature of witness

____
Person Signing on behalf of Patient*

____
Please print name

____
Please print name

*Please explain Representative's relationship to Patient and include a description of Representative's Authority to act on behalf of Patient: