AUTHORIZATION FOR RELEASE OF MEDICAL RECORDS/PERSONAL HEALTH INFORMATION
(OFFICE: USE WHEN PATIENT REQUESTS MEDICAL RECORDS/PHI BE SENT TO ANOTHER ENTITY)

This authorization is prepared pursuant to the requirements of the Health Insurance Portability and Accountability Act of 1996 (P.L. 104-191), 42 U.S.C. Section 1320d, et.seq., and regulations promulgated thereunder, as amended from time to time (collectively referred to as "HIPAA").

This authorization affects your rights in the privacy of your personal healthcare information. Please read it carefully before signing. Knee and Shoulder Institute (also known as covered entity) will not condition treatment payment, enrollment in a health plan, or eligibility for benefits, as applicable, on your providing authorization for the requested use or disclosure. YOU MAY REFUSE TO SIGN THIS AUTHORIZATION.

By signing this authorization you acknowledge and agree that Knee and Shoulder Institute may use or disclose ____(describe information) for the purpose(s) of ____(describe intended use).

By signing this authorization you agree that Knee and Shoulder Institute or its Business Associates may disclose your personal health care information to

____(identify intended recipients)

Further, by signing this authorization you acknowledge that you have been provided a copy of and have read and understand Knee and Shoulder Institute HIPAA Privacy Notice containing a complete description of your rights, and the permitted uses and disclosures, under HIPAA. While Knee and Shoulder Institute has reserved the right to change the terms of its Privacy Notice, copies of the Privacy Notice as amended are available from Knee and Shoulder Institute at any of its offices or by sending a written request with return address on the top of this form.

In accordance with your rights under, and subject to certain restrictions imposed by, HIPAA, you may inspect or copy your PHI in the designated record set maintained by Covered Entity for as long as the PHI is maintained in the designated record set.

You have the right to revoke this authorization, in writing, at any time, except to the extent that Knee and Shoulder Institute has taken action in reliance on it. A revocation is effective upon receipt by Knee and Shoulder Institute of a written request to revoke and a copy of the executed authorization form to be revoked at the address listed above.

THOMAS & BIGLER
KNEE & SHOULDER INSTITUTE

HIPAA PRIVACY
AUTHORIZATION FOR RELEASE OF MEDICAL RECORDS/PERSONAL HEALTH INFORMATION
KNEE AND SHOULDER INSTITUTE

This authorization shall expire upon the earlier occurrence of: (a) revocation of the authorization, (b) a finding by the Secretary of the U.S. Department of Health and Human Services, Office of Civil Rights that this authorization is not in compliance with requirements of HIPAA, (c) complete satisfaction of the purposes for which this authorization was originally obtained, to be determined in the reasonable discretion of Knee and Shoulder Institute, or (d) six years from the date this authorization was executed.

By signing this authorization you acknowledge and agree that any information used or disclosed pursuant to this authorization could be at risk for redisclosure by the recipient and no longer protected under HIPAA.

Knee and Shoulder Institute will provide «Pat_First_Name» «Pat_Last_Name» with a copy of this signed authorization.

Acknowledged and agreed to by:

PATIENT:

By____ Date: _________________________
«Pat_First_Name» «Pat_Last_Name»
«Pat_Address_1» «Pat_Address_2»
«Pat_City», «Pat_State» «Pat_Zip»

Or, ON BEHALF OF PATIENT

By____ Date:__________________________

Print Name_____________________________________
As____

Address: ____
____
____