ORTHOPAEDIC
ASSOCIATES
OF MICHIGAN

Limited Patient Authorization for Disclosure of Protected Health Information **Form 7.31**

Please print all information. Form must be signed and dated each year

Patient Name: ______________________________

Social Security Number or Account Number: ______________________________

Date of Birth: ______________________

Request for Disclosure of Patient Information - I authorize the Orthopaedic Associates of Michigan to disclose or provide protected health information, about me as stated in this authorization.

Who will provide or disclose information:

Orthopaedic Associates of Michigan

1111 Leffingwell NE

Grand Rapids, MI 49525

Phone: (616) 459-7101

Who will be authorized to receive information (family, friends, others)**:**

Name: ______________________________

Relationship: ______________ Phone: ____________ Fax: ______________

Address: ______________________________

Name: ______________________________

Relationship: ______________ Phone: ____________ Fax: ______________

Address: ______________________________

Name: ______________________________

Relationship: ______________ Phone: ____________ Fax: ______________

Address: ______________________________

Name: ______________________________

Relationship: ______________ Phone: ____________ Fax: ______________

Address: ______________________________

Reverse side must be completed and signed ⇒

Description of information to be disclosed - I authorize the practice to disclose the following protected health information about me to the entity, person, or persons identified above:

Entire patient record, including but not limited to (***check items to disclose***):

- ☐ office notes ☐ x-rays; hospital,
- ☐ nursing home, home health, hospice, and other physician records
- ☐ record of HIV and communicable disease testing
- ☐ record of mental health or substance abuse treatment
- ☐ financial history report (previous 3 years only).

☐ Office notes and x-rays only.

☐ Only send the following: ____

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Purpose of disclosure (please check the purpose of the disclosure or check patient request):

☐ Patient Request

☐ Patient transferring to our care.

☐ Patient referred to us for treatment of: ____

☐ Other (please specify): ____

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Expirations or termination of authorization: This authorization will expire at the end of the calendar year of your signature below, unless you specify an earlier termination. You must submit a new authorization after the expiration date to continue the authorization. You have the right to terminate this authorization at any time. You must notify our privacy manager, in writing, if you decide to terminate the authorization prior to the normal expiration date.

(Please list an earlier expiration if less than one year)____

Right to revoke or terminate: As stated in our Notice of Privacy Practices, you have the right to revoke or terminate this authorization by submitting a written request to our Privacy Manager.

Non-Conditioning statement: The practice places no condition to sign this authorization on the delivery of healthcare or treatment.

Rediscloure: We have no control over the person(s) you have listed to receive your protected health information. Therefore, your protected health information disclosed under this authorization will no longer be protected by the requirements of the Privacy Rule and will no longer be the responsibility of the practice.

X____ ____________________

Patient Signature Date

You have the right to receive a copy of signed authorizations upon request.