Northwest Ohio Orthopedics & Sports Medicine, Inc.

HIPAA Privacy Authorization Form

Authorization for Use or Disclosure of Protected Health Information

Patient Name: _____ DOB: _____

Release of Information

I authorize the release of information to the following individuals:

*please indicate emergency contact

Name: _____Relationship: _____

Contact Number: _____ □ Emergency Contact

Name: _____Relationship: _____

Contact Number: _____ □ Emergency Contact

Name: _____Relationship: _____

Contact Number: _____ □ Emergency Contact

□ **Information is NOT to be released to anyone**

The ***Release of Information*** will remain effect for twelve (12) months.

Messages

Please contact me by: □**Phone #:**_____

□**Leave Detailed Message**

□ **Leave Message to return call**

This authorization shall be in force and effect until nine (9) months after my death, at which time this authorization expires.

I understand that I have the right to revoke this authorization, in writing, at any time. I understand that a revocation is not effective to the extent that any person or entity has already acted in reliance on my authorization or if my authorization was obtained as a condition of obtaining insurance coverage and the insurer has a legal right to contest a claim.

I understand that information used or disclosed pursuant to this authorization may be disclosed by the recipient and may no longer be protected by federal or state law.

_____ Date: _____

Signature of Patient (Parent/ Guardian, if Minor)

Staff Signature/Date as Witness: _____