

**AUTHORIZATION FOR USE OR DISCLOSURE OF
PROTECTED HEALTH INFORMATION TO LOUISVILLE ORTHOPAEDIC CLINIC**

I, _____, hereby authorize Louisville Orthopaedic Clinic, PSC to use and/or disclose my protected health information described below to: *[Name of entity or persons to receive information]*

My protected health information will be used or disclosed upon request for the following purposes. *[Please name and explain each purpose]*

This authorization for use and/or disclosure applies to the information described below:
[Mark those that apply]

- Any and all records in the possession of Louisville Orthopaedic Clinic, PSC, 4130 Dutchmans Lane, Suite 300, Louisville, Kentucky 40207 including mental health, HIV and/or substance abuse records *[Cross out any item you do not authorize to be released and initial here _____ to confirm you have made changes].*
- Records regarding treatment for the following condition or injury: _____
_____ on or about _____
- Records covering the period of time _____ to _____
- Other *[Please specify and include dates]:* _____

I understand that I have the right to revoke this authorization, in writing, at any time by sending such written notification to Louisville Orthopaedic Clinic, PSC, 4130 Dutchmans Lane, Suite 300, Louisville, Kentucky 40207. I also understand that my revocation is not effective to the extent that the persons I have authorized to use and/or disclose my protected health information have acted in reliance upon this authorization.

This authorization expires on *[Please specify date or event]:* _____
If expiration is blank, authorization will be valid until such time that it is revoked in writing.

I understand that I do not have to sign this authorization and that Louisville Orthopaedic Clinic, PSC may not deny treatment or payment on whether I sign this authorization, but release of information to outside entities other than for billing or treatment purposes will not be made.

I understand that information used or disclosed pursuant to this authorization may be subject to re-disclosure by the recipient and may no longer be protected by federal laws and regulations regarding privacy of my protected health information.

Signature of Patient or Personal Representative

Date

Print Name of Patient or Personal Representative

Description of Personal Rep's Authority (copy on file or attached)

Patient Date of Birth

