# Authorization for Inland Orthopaedics to Disclose My Health Care Information

This needs to include: Parents, Spouse, Children, & any other person(s) you want authorization for.
We cannot discuss treatment with your family without this authorization.

Patient Name: _____ Date of Birth: _____

Previous Name: _____

**I. My Authorization**

**You may use or disclose the following health care information (check all that apply):**

- ☐ All health care information in my medical record.
- ☐ Health care information in my medical record relating to the following treatment or condition:

  _____
- ☐ Health care information in my medical record for the dates: _____
- ☐ Other (eg., x-rays, bills), specify dates(s): _____

**You may disclose health care information to:**

Name: _____ Relationship: _____ Phone # _____

Address: _____

**You may disclose health care information to:**

Name _____ Relationship: _____ Phone # _____

Address: _____

☐ **This Authorization Ends**: (this document does not permit disclosure of health information created more than 90 days after the date it is signed.)

_____ _____

Patient or legally authorized individuals signature Date Time

_____ _____

Printed name if signed on behalf of the patient Relationship

Once health care information is disclosed, the person or organization that receives it may re-disclose it. Privacy laws may no longer protect it.