

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.