PROLIANCE ORTHOPEDIC ASSOCIATES
Specializing in What Moves You

PROLIANCE SURGEONS®

Authorization For Proliance Orthopedic Associates, a division of Proliance Surgeons, Inc., P.S., to Use or Disclose My Health Care Information

Questions marked with a (*) are mandatory. Your request may not be fulfilled without the information provided.

***PATIENT NAME:**_____ ***Phone:**_____ ***DATE OF BIRTH:**_____

You may disclose this health care information TO:

***Name (or title) and organization:**_____ _____

Address:**_____ ***City:**_____State:**_____ ***Zip:**_____

***Phone:**_____ ***(If applicable)Fax:**_____

***VIA (circle one):** **MAIL** **FAX** **CD** **PICK-UP (COVINGTON / RENTON)**
(Circle one)

I. My Authorization

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

- ☐ Current Medical Records information (clinic notes, radiology reports, MRI reports, operative notes etc for last date of service also to include 12 months prior)
- ☐ Health care information (notes/reports) in my medical record related to the following treatment or condition:_____
- ☐ Health care information in my medical record (notes/reports) for the date (s)_____
- ☐ X-ray images **(mail or pick up ONLY)**
- ☐ MRI images **(mail or pick up ONLY)**
- ☐ Billing information
- ☐ Other - specify information & date(s)_____
- ☐ All Medical Records information (All clinic notes, radiology reports, MRI reports, operative notes etc)

You may use or disclose health care information regarding testing, diagnosis, and treatment for (check all that apply)

- ☐ HIV (AIDS Virus)
- ☐ Sexually Transmitted diseases
- ☐ Psychiatric disorders / mental health
- ☐ Drug and/or alcohol use

***Reason(s) for this authorization (check all that apply)**

- ☐ At my request *(Default answer if nothing chosen)*
- ☐ Other (specify)_____
- ☐ Practice requests the authorization for **marketing purposes**
- ☐ Practice will be **paid** for something of value for providing health information for **marketing purposes**

This authorization ends: *(if disclosure is to a financial institution or employer of the patient for purposes other than payment, then as to those disclosures this authorization expires **90** days after signed, unless renewed.)*

- X When the following event occurs: *Completion of this signed document or* _____

II. My Rights –

I understand that I do not have to sign this authorization in order to get health care benefits (treatment, payment or enrollment) However, I do have to sign an authorization form:

- To take part in a research study or
- To receive health care when the purpose is to create health care information for a third party. I may revoke this authorization in writing. If I did, it would not affect any actions already taken by Valley Orthopedic Associates, a division of Proliance Surgeons, Inc., P.S. based upon this authorization. I may not be able to revoke this authorization if its purpose was to obtain insurance. Two ways to revoke this authorization are:
  - Fill out a revocation form. A form is available at the practice. Or
  - Write a letter to the practice

A copy fee may apply when records are released to a patient or other non-physician recipient. If a fee is applicable, you will be contacted.

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

_____ _____

Patient or legally authorized individual signature **Date**

_____ _____

Printed name if signed on behalf of patient **Relationship (parent, legal guardian, personal representative)**