OrthoSports Associates, LLC

Patient Authorization for Use and/or Disclosure of Protected Health Information

Patient Name:	Date of Birth:
Address:	Social Security Number:

I hereby authorize OrthoSports Associates, LLC ("OrthoSports") to use, disclose and/or obtain my health information as follows (*check all that apply*):

□ **use the following health information maintained by OrthoSports until:**	□ **disclose the following health information to**:	□ **obtain the following health information from:**
_____ **Expiration Date/ will expire one year from signed date unless otherwise specified above.**	_____ **Address**:_____ **City, State, Zip**:_____ **Phone**:_____	_____ **Address:**_____ _____ _____

Specific description of the health information to be used/disclosed/obtained (*include dates of service, i.e., appointment date, type of service, etc):*_____
_____
_____

This health information is used/disclosed/obtained for the following purpose (*if Authorization requested by the patient put: "At the request of the individual"*):_____
_____

By providing this Authorization, I understand as follows:

1. **I understand that this Authorization may result in the sending of clinical information and x-rays with reference to the above-named patient's diagnosis and/or any alcohol, drug or child abuse problems, behavioral or mental health services, and/or information concerning sexually transmitted disease, acquired immunodeficiency syndrome (AIDS), or human immunodeficiency syndrome (HIV). I understand that these records are strictly confidential and are solely for the information of the person to whom addressed.**

2. I understand that this Authorization is voluntary. I may refuse to sign this Authorization and the above-named patient's treatment and/or payment obligations will not be affected unless either of the following applies:

   - □ My treatment is related to research and the use and/or disclosure is related to such research; or
   - □ My treatment is solely for the purpose of creating protected health information for disclosure to a third party.

3. I understand that OrthoSports will not receive financial or in-kind compensation or remuneration in exchange for the use and/or disclosure of the above-named patient's protected health information unless an applicable legal exception applies.

4. I understand that the health information to be released may be subject to redisclosure by the recipient of the health information and no longer protected by federal or state law.

5. I understand that this Authorization is continuous in nature and is to be given full force and effect, including disclosing and/or utilizing any and all of the foregoing information learned or determined after the date hereof but prior to the expiration date noticed below.

6. I understand that I may revoke this Authorization at any time by notifying OrthoSports in writing, but if I do, it will not have any effect on uses or disclosures prior to the receipt of the revocation. Unless otherwise revoked, this Authorization will expire on _____ (date, event, or condition). If I fail to specify a date, event, or condition, this Authorization will expire in one (1) year.

7. I understand that, upon request, I may receive a copy of this Authorization form after I sign it.

8. I understand that a photocopy or facsimile of this Authorization shall be valid and effective, just as the original.

_____ _____

Signature of Patient or Patient's Representative Date:

_____

Printed Name of Patient's Representative (*if applicable*)

_____

Representative's Relationship to Patient (*if applicable*)

If applicable, mail or fax records to:

☐ St. Vincent's Birmingham
833 St. Vincent's Drive, P.O.B. 3, Suite 403
Birmingham, AL 35205
Phone: 205-939-0447
Fax: 205-939-0418

☐ Princeton Medical Center
817 Princeton Avenue, P.O.B. 1, Suite 108
Birmingham, AL 35211
Phone: 205-781-1950
Fax: 205-787-0057

☐ St. Vincent's East
48 Medical Park East Drive, Suite 255
Birmingham, AL 35235
Phone: 205-838-3090
Fax: 205-838-6892

☐ Hoover Medical Plaza
2010 Patton Chapel Road North, Suite 100
Birmingham, AL 35216
Phone: 205-783-5511
Fax: 205-978-7776

☐ St. Vincent's East
52 Medical Park East Drive, Suite 220
Birmingham, AL 35235
Phone: 205-838-4747
Fax: 205-838-2712