

Authorization for Use and Disclosure of Protected Health Information

1. PATIENT

Patient Name (print) _____ Date of Birth _____ Phone _____

Address _____

2. DIRECTION OF RELEASE (check one)

I hereby authorize the release of my health information as follows (the releasing party is the "**Releasing Provider**"):

- ☐ From **DC Orthopedics, LLC** to the provider or party named below.
- ☐ From the provider or party named below **to DC Orthopedics, LLC** · Fax: **301-547-6874**

Name of Other Provider / Party _____ Phone _____ Fax _____

Address _____ Email _____

3. PURPOSE

☐ Continuing care ☐ Personal use ☐ Legal / insurance ☐ Other: _____

4. HEALTH INFORMATION TO RELEASE

The following "**Health Information**" may be used and disclosed by the Releasing Provider. *Check and initial.*

RECORDS TO RELEASE	YES	INITIAL
My complete medical and billing record (all of the below)	☐	_____
Rehabilitation / therapy record	☐	_____
Billing record only	☐	_____
Record relating to the _____ date of injury	☐	_____
Record for the following date(s) of service: _____	☐	_____
Other: _____	☐	_____

I understand that the terms of this Authorization are governed by the Health Insurance Portability and Accountability Act of 1996 and its implementing regulations, as may be amended from time to time ("**HIPAA**"), and applicable state law. I understand that I have the right to revoke this Authorization at any time prior to the Releasing Provider's compliance with the request set forth herein, provided that the revocation is in writing. I further understand that additional information relating to the exceptions to the right to revoke and a description of how I may revoke this Authorization is set forth in the Releasing Provider's Notice of Privacy Practices. I understand that any revocation must include my name, address, telephone number, date of this Authorization and my signature, and that I should send it to the Releasing Provider. Revocations for DC Orthopedics should be sent to: **DC Orthopedics, LLC, Attn: Privacy Officer, 5530 Wisconsin Ave, Suite 1149, Chevy Chase, MD 20815.**

I understand that I am not required to sign this Authorization and that the Releasing Provider may not condition my treatment on my execution of this Authorization. I understand that the Health Information used or disclosed pursuant to this Authorization may be subject to re-disclosure by the recipient and, in that case, may no longer be protected by HIPAA. This Authorization expires automatically upon the Releasing Provider's disclosure of my Health Information as necessary to fully accomplish the intent hereof, but in no event later than one year from the date of my signing.

5. SIGNATURE

Signature of Patient or Legal Representative _____ Date _____

Printed Name of Signer (if not patient) & Relationship _____