Kerlan - Jobe Orthopaedic Clinic
Authorization for Use or Disclosure of Health information

The completion of this document authorizes the disclosure and/or use of individually identifiable health information as set forth below consistent with California and Federal law concerning the privacy of such information. Failure to provide all information requested may invalidate this authorization. Your request will be processed and fulfilled within 4-7 business days from the day it is received.

Fees: $20.00 - records (copy)
$15.00 - per sheet of film

Patient Name: ____________________ Date of Birth: ____________

Address: ____________________ Telephone: ____________

____________________ ____________

I, ______________________, hereby authorize Kerlan - Jobe Orthopaedic Clinic to the use and/or disclosure of my health information as follows:

Person/Organizations authorized to use and/or disclose the information: ____________________

Person/Organizations authorized to receive the information: ____________________

Address of person/organization to receive the information: ____________________

This authorization applies to the following information:

_______ Entire record _______ These specific dates only: ____________________

_______ X-Ray films Dates: ____________________

Purpose of use or disclosure of information:

_______ To comply with court order _______ Required for insurance claim _______ Application for insurance

_______ For personal use _______ Payment of a bill _______ Other ____________

_______ For follow-up care _______ To update medical records ____________________

Expiration: ____________________ (This authorization expires-insert date/event)

Restrictions: California law prohibits the requestor from making further disclosures of my health information, unless the requestor obtains another authorization from me or unless such disclosure is specifically required or permitted by law.

Patient's rights:

- I further understand that I have a right to receive a copy of the authorization upon my request
  Copy requested and received: ☐ YES ☐ NO __________ INITIAL
- I may revoke this authorization at any time. My revocation must be in writing, signed by me or on my behalf and delivered to the following address: ____________________
- My revocation will be effective upon receipt, but will not be effective to the extent that the requestor or others have acted in reliance upon this authorization.
- I have right to receive a copy of this authorization.

SIGNATURE:

Date: ____________ Time: ____________ AM/PM

Signature: ______________________________
(patient/representative/spouse/financially responsible party)

If signed by someone other than the patient state your legal relationship to the patient:

Witness: ______________________________

(If you have authorized the disclosure of your health information to someone who is not legally required to keep it confidential, it may no longer be protected. California law prohibits recipients of your health information from redisclosing such information except with your written authorization or as specifically required or permitted by law.)

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