Authorization for Use and Disclosure of Protected Health Information (PHI)

Plano Orthopedic Sports Medicine & Spine Center, P.A.

5228 W. Plano Pkwy • Plano, TX 75093
Phone: 972-250-5700 Fax: 972-250-5749

Patient Legal Name: ________________________ DOB: ______________ SS#: ________________

Address: ____________________________________ Phone #: __________________________

City: ____________________ State: ____________________ Zip Code: ____________________

I Hereby Authorize: ***Plano Orthopedic Sports Medicine and Spine Center, P.A.***;
Facility or Covered Entity

To disclose medical record information and/or Protected Health Information (PHI) of the patient listed above to:

Name/Title: ____

Address: ____

Purpose: ____

For Treatment Date (s): ____

Type of Access Requested:		***Select Portions of PHI:***	
_____ Copies of the Record	_____ Emergency Room	_____ Lab	_____ Out Patient Rehab
_____ View In House Record	_____ History & Physical	_____ Radiology Reports	_____ Progress Notes
	_____ Consult Report	_____ Radiology Films	_____ Physician Orders
	_____ Operative Report	_____ Path Report	_____ Entire Record
	_____ Discharge Summary	_____ Face Sheet	_____ Other
		_____ Medication Record	

______ I acknowledge, and herby consent to such, that the released information may contain alcohol, drug abuse, psychiatric, HIV
(INITIALS) testing, HIV results or AIDS information.

EXPIRATION: *This authorization shall expire on the 180th day after it is signed, unless as provided otherwise upon Expiration Date or Event given here:*
____

I Understand That:

- This authorization may be revoked by me at any time except to the extent that action has been taken in reliance upon it.
- Treatment and payment may not be conditioned on obtaining this authorization.
- The information used or disclosed pursuant to the authorization may be subject to redisclosure by the recipient and no longer protected.
- Fees/Charges will comply with all laws and regulations applicable to release of information.
- I get a copy of this form after I sign it.

I have read the above and authorize the disclosure of the protected health information as stated.

______________________________ ______________________ ______________
Signature of Patient/Parent/Patient Representative Relationship to Patient Date

____
Address and Telephone # of Requestor (IF DIFFERENT FROM PATIENT INFORMATION)