

**ST. VINCENT'S ORTHOPEDICS, P.C.**  
Authorization to Disclose Health Information

Patient Name \_\_\_\_\_ SSN \_\_\_\_\_  
Address \_\_\_\_\_

1. I authorize St. Vincent's Orthopedics, P.C. to use or disclose the above named Individual's health information as described below.
2. The type and amount of information to be used or disclosed is as follows:  
(include dates where appropriate)

\_\_\_\_ Patient Account Statement/Billing Records  
\_\_\_\_ X-ray and imaging reports                      From (date) \_\_\_\_\_ to (date) \_\_\_\_\_  
\_\_\_\_ Laboratory results                                      From (date) \_\_\_\_\_ to (date) \_\_\_\_\_  
\_\_\_\_ Entire Record  
\_\_\_\_ Other

3. I understand that the information in my health record may include information relating to sexually transmitted disease, acquired immunodeficiency syndrome (AIDS), or human immunodeficiency virus (HIV). It may also include information about behavioral or mental health services, and treatment for alcohol and drug abuse.
4. This information may be disclosed to and used by the following individual or organization:

Physician: \_\_\_\_\_  
Address: \_\_\_\_\_  
Phone Number: \_\_\_\_\_ Fax Number \_\_\_\_\_

5. I understand that I have the right to revoke this authorization at any time. I understand that if I revoke this authorization I must do so in writing and present my revocation to the Privacy Officer of St. Vincent's Orthopedics, P.C. I understand that the revocation will not apply to information that has already been released in response to this authorization. I understand that the revocation will not apply to my insurance company when the law provides the insurer with the right to contest a claim under my policy. If I fail to specify an expiration date, event or condition this authorization will expire in twelve (12) months.
6. I understand that authorizing the disclosure of this health information is voluntary and I can refuse to sign this authorization. I need not sign this form in order to assure treatment. I understand that I may inspect or copy the information to be used or disclosed, as provided in CRF 164.524 of the Federal Register Rules and Regulations. I understand that any disclosure of information carries with it the potential for an unauthorized redisclosure and the information may not be protected by federal confidentiality rules. If I have questions about disclosure or my health information. I can contact the the Privacy Officer for St. Vincent's Orthopedics, P.C.

Patient Signature \_\_\_\_\_ Date \_\_\_\_\_

\_\_\_\_\_  
If signed by Legal Representative, Relationship to Patient                      Signature of Witness