David P. Adkison, M.D.
James R. Bowman, M.D
Jeffrey R. Cusmariu, M.D.
Eli J. Hurowitz, M.D.

St. Vincent's Orthopedics, PC

Authorization to Obtain/Disclose Health Information

Edward U. Kissel, III, M.D.
J. Todd Smith, M.D.
James V. Worthen, M.D.

Patient Name: _____

Date of Birth: _____ **SSN:** _____

Address: _____

Phone #: _____ **Alternate #:** _____

1. I authorize St. Vincent's Orthopedics, P.C. to obtain/disclose and/or use the above named individuals health information as described below.

2. The type and amount of information to be obtained/disclosed or used is as follows:
(Include dates where appropriate)

_____ Patient Account Statement/Billing Records
_____ X-Ray and Imaging Films and/or Reports
_____ Laboratory Results
_____ Operative Reports/Records
_____ Office Notes
_____ Entire Medical Record
_____ **OTHER:** _____

3. I understand that the information in my health records 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/or drug abuse.

4.

This information may be obtained from:	**It may be disclosed to: (REQUIRED)**
Physician: _____	_____
Address: _____	Address: _____
_____	_____
Phone #: _____	Phone #: _____
Fax #: _____	Fax #: _____

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 obtained/disclosed in response to this authorization. I understand that the revocation will not apply to my insurance company when the law provides the insured 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/obtaining 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 Regulation. I understand that any disclosure of information carries with it the potential for an unauthorized re-disclosure and the information may not be protected by federal confidentiality rules. If I have questions about disclosure and/or the requesting of my health information, I can contact the Privacy Officer for St. Vincent's Orthopedics, P.C.

Patient Signature: _____ **Date:** _____

_____ _____
If signed by Legal Representative, Relationship to Patient | Signature of Witness

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