GEORGIA
BONE & JOINT
SURGEONS, P.C.

PATIENT AUTHORIZATION FOR USE AND DISCLOSURE PROTECTED HEALTH INFORMATION

I hereby authorize Georgia Bone & Joint Surgeons, P.C. and/or Center for Orthopedic Surgery to use and/or disclose certain protected health information (PHI) about me to:

___

Information to be released:

☐ Complete records (office note, test results, etc.)
☐ Copies of x-rays
☐ Clinic/Office visit notes only
☐ Special procedure/test results only
☐ Other: ___

The above information will be used or disclosed for the following purpose: ___

At the request of the individual or: ___

This authorization will expire 365 days from date of this notice or on: ___

The practice will not receive payment or other remuneration from a third party in exchange for using or disclosing the PHI. I do not have to sign this authorization in order to receive treatment from Georgia Bone & Joint Surgeons, P.C. and/or Center for Orthopedic Surgery. In fact, I have the right to refuse to sign this authorization and to revoke this authorization at any time except to the extent that the practice has acted in reliance upon it. When my information is used or disclosed pursuant to this authorization, it may be subject to redisclosure by the Recipient and no longer be protected by the Federal HIPAA Privacy Rule. My written revocation must be submitted in writing to Vickie Edwards, Georgia Bone & Joint Surgeons, P.C., 15 Medical Drive, Cartersville, GA 30121.

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Signature of Patient or Guardian | Date | Relationship to Patient

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Printed Name of Patient | Date of Birth | Printed Name of Legal Guardian

PATIENT/GUARDIAN TO BE PROVDIED WITH A SIGNED COPY OF THIS AUTHORIZATION