



Authorization to Use or Disclose My Health Information

Patient information (please print):

Date: _____

Patient Name: _____ Date of Birth: _____

Previous Name: _____ Phone Number: _____

I. My Authorization

You may use or disclose the following health care information (check all that applies):

- ☐ My health information maintained by the below named practice for dates: _____ to _____
(Circle Include or Exclude for each of the following)
- ☐ Include or Exclude: My health information related to drug use
- ☐ Include or Exclude: My health information related to alcohol abuse
- ☐ Include or Exclude: My health information related to HIV / AIDS
- ☐ Include or Exclude: My health information related to psychological or psychiatric conditions, including psychotherapy notes
- ☐ My health information relating to the following treatment or condition: _____
- ☐ Other: _____

I hereby authorize:

Name (or title)/Facility: _____

Address: _____ City/State: _____ Zip Code: _____

Phone: _____ Fax: _____

You may disclose this health information to:

Great Lakes Orthopedics & Sports Medicine, P.C.

9615 Keilman St St John, IN 46373

Phone: (219) 365-0220 Fax: (219) 365-0226

Reason (s) for this authorization (check all that apply):

- ☐ At my request
- ☐ Other (specify) _____
- ☐ Check here only when Great Lakes Orthopedics & Sports Medicine, P.C. requests the authorization for marketing purposes
- ☐ Check here only when Great Lakes Orthopedics & Sports Medicine, P.C. will get something

IMPORTANT—If patient is deceased, please INITIAL one of the statements below:

_____ I am the Administrator/Executor for the deceased & Letters of Testamentary (or comparable documents) are attached.

_____ There is no court appointed Administrator/Executor and I am the next of kin.

This authorization ends:

On (date) _____ When the following event occurs _____

II. My Rights:

I understand I do not have to sign this authorization in order to get health care benefits (treatment, payment or enrollment).

However, I do have to sign an authorization form: To take part in a research study or To receive health care when the purpose is to create health information for a third party

I may revoke this authorization in writing. If I do, it will not affect any actions already taken by the above named practice base upon this authorization. I may not be able to revoke this authorization if its purpose was to obtain insurance. I may revoke this authorization by writing a letter to the office.

Once the office discloses health information, the person or organization that receives it may re-disclose it. Privacy laws may no longer protect it.

Patient or legally authorized individual signature

Date

Time

Printed Name if signed on behalf of the patient

Relationship (parent, legal guardian, personal representative, etc.)