GREAT LAKES ORTHOPEDICS & SPORTS MEDICINE, P.C.

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 heath information relating to the following treatment or condition: _____

☐ Other: _____

I hereby authorize:

Great Lakes Orthopedics & Sports Medicine, P.C.

9615 Keilman St St John, IN 46373

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

You may disclose this health information to:

Name (or title)/Facility: _____

Address: _____ City/State _____ Zip Code: _____

Phone: _____ Fax: _____

Records are to be released via: ☐ Pick up by _____ ☐ Mail *(Above address only)* ☐ Fax
Name of person picking up records

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.)