



Authorization for Access, Use, and Disclosure of Protected Health Information (PHI)

Patient Information

Patient Name: _____ DOB: _____

Address: _____

Phone: _____ Claim #: _____

Authorization

I hereby authorize **Movement Orthopedics, PLLC** to release and/or disclose my protected health information (PHI) to the following individual(s) or organization(s):

Release Information To:

Name / Organization: _____

Address: _____

Phone: _____ Fax: _____

Information to Be Released

- Complete medical records Office visit notes Operative reports
- Lab/pathology results Diagnostic imaging/X-rays Physical therapy records
- Work status reports Billing records Other: _____

Purpose of Disclosure

- Workers' compensation claim Legal/Attorney request Insurance purposes
- Continuing care Personal/Patient request Other: _____

Terms

This authorization is voluntary. I understand that I may revoke this authorization at any time by submitting a written request to Movement Orthopedics, except to the extent that action has already been taken in reliance on this authorization. This authorization expires one (1) year from the date signed below, unless otherwise specified: _____

I understand that information disclosed pursuant to this authorization may be subject to re-disclosure by the recipient and may no longer be protected by federal privacy regulations.

Patient Signature (or Legal Representative)

Date

If signed by legal representative:

Printed Name: _____ Relationship: _____

