**ORTHOPEDIC ASSOCIATES OF LONG ISLAND, LLP**

# PATIENT AUTHORIZATION FOR USE AND DISCLOSURE OF PROTECTED HEALTH INFORMATION

**Patient Name:** ______________________________ **Date of birth** ______________ **Doctor seen:** ____________

By signing this authorization, I authorize Orthopedic Associates of Long Island, LLP to use and/or disclose certain protected health information (PHI) about me. Please send information to:

**(name)**____________________________________

**(Address)**.____________________________________________________________________________.

**If you want this faxed, please add fax number**: ________________________________________

This authorization permits Orthopedic Associates of Long Island, LLP to use and/or disclose the following individually identifiable health information about me (specifically describe the information to be used or disclosed, such as date(s) of services, type of services, level of detail to be released, origin of information, etc.):

_________________________________________________________________________________

_________________________________________________________________________________.

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

__________________________________________________________________________________.

**If requested by the patient, purpose may be listed as "at the request of the individual.")**

The purpose(s) is/are provided so that I can make an informed decision whether to allow release of the information. This authorization will expire on ________ __________________________________
{Expiration Date or Defined Event}.

The Practice will ___ will not XX 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 Orthopedic Associates of Long Island ,LLP. In fact, I have the right to refuse to sign this authorization. When my information is used or disclosed pursuant to this authorization, it may be subject to redisclosure by the recipient and may no longer be protected by the federal HIPAA Privacy Rule. I have the right to revoke this authorization in writing except to the extent that the practice has acted in reliance upon this authorization. My written revocation must be submitted to Stephen Goldstein, the Privacy Officer, at:

6 Technology Drive, Suite 100
Address

| East Setauket | NY | 11733 |
|---|---|---|
| City: | State | Zip Code |

Signed by:__________________________________ __________________________________

Signature of Patient or Legal Guardian — Relationship to Patient

____________________________ ________________________

Print Patient's Name — Date

rev. 02/10

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Print Name of Legal Guardian (if applicable)

*PATIENT/GUARDIAN TO BE PROVIDED WITH A SIGNED COPY OF AUTHORIZATION*