

## AUTHORIZATION FOR THE USE AND DISCLOSURE OF PROTECTED HEALTH INFORMATION

## HIPAA COMPLIANT AUTHORIZATION FOR RELEASE OF INFORMATION (42 CFR §164.508)

correspondence, test results, subjective and objective complaints, statements, questionnaires/histories, office and doctor's handwritten notes; and records received from other physicians or healthcare providers;  All autopsy, laboratory, histology, cystology, pathology, radiology, CT Sean, MRI, echocardiogram & cardiac catheterization reports;  All radiology films; mammograms; myelograms; photographs, CT Seans; hone scans, pathology, cytology, histology, autopsy, immuno-histochemistry specimens; cardiac catheterization videos; and chocardiogram videos;  All prescription and pharmaceutical records, including, but not limited to: NDC numbers and drug information handouts/monographs;  All observation of the description and pharmaceutical records, including, but not limited to: NDC numbers and drug information handouts/monographs;  All observation of the description and pharmaceutical records, including, but not limited to: NDC numbers and drug information handouts/monographs;  All observation of the description and pharmaceutical records, including, but not limited to: NDC numbers and drug information handouts/monographs;  All observation of the disclosure of the control of the catherial records, including, but not limited to: All the disclosure will be determined by Mich-America Orthopedics, LLC.) Please provide an email address for electronic format:  1	PATIENT NAME:	o/o/B
Information Requested: 1 consent and authorize	PARENTS NAME (IF INDIVIDUAL UNDER AGE OF 18):	
in any form (including oral, written or electronic) to	Previous Name/Alias (if applicable):	
mail of facsimile. I expressly request that Mid-America Orthopedics, LLC disclose full and complete PHI from the time period of to provide including, but not limited to, the following:  • All medical records, including, but not limited to: inpatient, outpatient & emergency room treatment; all clinical charts, reports, documents, correspondence, test results, subjective and objective complaints, statements, questionmaires/histories, office and doctor's handwritten notes; and records received from other physicians or healthcare providers.  • All autopsy, laboratory, histology, cystology, pathology, radiology, CT Scan, MRI, echocardiogram & cardiac catheterization reports;  • All autopsy, laboratory, histology, cystology, pathology, andiology, CT Scan, MRI, echocardiogram & cardiac catheterization reports;  • All autopsy, laboratory, histology, cystology, pathology, radiology, CT Scan, MRI, echocardiogram & cardiac catheterization reports;  • All autopsy, laboratory, histology, cystology, pathology, radiology, CT Scan, MRI, echocardiogram & cardiac catheterization reports;  • All autopsy, laboratory, histology, cystology, pathology, radiology, CT Scan, MRI, echocardiogram & cardiac catheterization reports;  • All autopsy, laboratory, histology, cystology, pathology, radiology, CT Scan, MRI, echocardiogram & cardiac catheterization reports;  • All prescription and pharmaceutical records, including, but not limited to: All carespondence to/frontabout reports, and telephone messages;  • All billing records, including, but not limited to: all statements, invoices, itemized bills, and insurance records;  • All correspondence to/frontabout me, enabled to the management of the pathology, radiops, and pathology, and pathology, radiops, and records and pathology, radiops, and pathology, radiops, and pathology, radiops, and pathology,	Information Requested: I consent and authorizein any form (including oral, written or electronic) to	to disclose all Protected Health Information ("PHI")
correspondence, test results, subjective and objective complaints, statements, questionnaires/histories, office and doctor's handwritten notes; and records received from other physicians or healthcare providers;  All autorpsy, laboratory, histology, cystology, pathology, radiology, CT Scan, MRI, echocardiogram & cardiac catheterization reports;  All radiology films; mammograms; myelograms; photographs, CT scans; bone scans, pathology, cytology, histology, autopsy, immuno-histochemistry specimens; cardiac catheterization videos; and echocardiogram videos;  All correspondence toffrondabout me, memos, office notes, narrative summaries, and telephone messages;  All billing records, including, but not limited to: all statements, invoices, itemized bills, and insurance records;  All correspondence toffrondabout me, memos, office notes, narrative summaries, and telephone messages;  All billing records, including, but not limited to: all statements, invoices, itemized bills, and insurance records;  All documents related to the amendment of any record requested.  Irequest the information be disclosed in the following format  It acknowledge that Mid-America Orthopedics, LLC.) Please provide an email address for electronic format:  I acknowledge that Mid-America Orthopedics, LLC. is receiving remuneration in the amount of for this disclosure.  I year from Authorization Effective until:  I year from Authorization of the subtrolization of the polytoped and the polytoped and the polytoped and polytoped	mail or facsimile. I expressly request that Mid-America Orth	nopedics, LLC disclose full and complete PHI from the time period of
I acknowledge that Mid-America Orthopedics, LLC is receiving remuneration in the amount of for this disclosure.    AUTHORIZATION EFFECTIVE UNTIL:     DATE   OTHER EVENT OCCURS     I YEAR FROM DATE OF THIS AUTHORIZATION   PATE OF THIS AUTHORIZE RE-DISCLOSURE OF MEDICAL INFORMATION HIS BEEN DISCLOSED HIROUGH RECORDS THAT ARE PROTECTED BY SHORMATION HAS BEEN DISCLOSED HIROUGH RECORDS THAT ARE PROTECTED BY SHORMATION HAS BEEN DISCLOSED HIROUGH RECORDS THAT ARE PROTECTED BY SHORMATION HAS BEEN DISCLOSED HIROUGH RECORDS THAT ARE PROTECTED BY SHORMATION HAS BEEN DISCLOSED HIROUGH RECORDS THAT ARE PROTECTED BY SHORMATION HAS BEEN DISCLOSED PROTECTED BY SHORMATION HAS BEEN DISCLOSED THIS PROTHER LAW, FURTHER LAW, FURTHOUT SHEEDER WRITTEN CONSENT OF THE INDIVIDUAL OR AS OTHERWISE PERMITTED BY SUCH LAW AND/OR REGULATIONS. A GENERAL AUTHORIZATION IS NOT SUPPLICENT FOR THISSE PURPOSES.  Signature of Patent of Patent of Legal Representative (if applicable): Date Date Date Date	correspondence, test results, subjective and objective or records received from other physicians or healthcare properties. All autopsy, laboratory, histology, cystology, pathology all radiology films; mammograms; myelograms; photochemistry specimens; cardiac catheterization videos; an All prescription and pharmaceutical records, including, All correspondence to/from/about me, memos, office not all billing records, including, but not limited to: all state. All documents related to the amendment of any record in the request the information be disclosed in the following forms:	omplaints, statements, questionnaires/histories, office and doctor's handwritten notes; and oviders;  to radiology, CT Scan, MRI, echocardiogram & cardiac catheterization reports; tographs, CT scans; bone scans, pathology, cytology, histology, autopsy, immuno-histode echocardiogram videos; but not limited to: NDC numbers and drug information handouts/monographs; totes, narrative summaries, and telephone messages; tements, invoices, itemized bills, and insurance records; requested.  at
I understand that this authorization may be revoked at any time, except to the extent already acted upon, by giving written notice to Requestor at the address listed above. I understand that treatment, payment, enrollment or eligibility for benefits may not be conditioned upon signing this authorization. I understand that the Requestor may redisclose this information, and if re-disclosed, the information would no longer be protected by federal privacy rules and regulations. Any facsimile or copy of this authorization authorizes the release of the records requested herein.  Signature of Patient (if 18 years of age or older):  Date  Relationship to Patient, if not signed by Patient:  In addition to the authorization provisions above, I authorize the release and re-disclosure of all information, data, notes, records, reports, and all other documents to the Requestor, its consultants, experts, agents and/or other counsel relating to:  Substance Abuse (Alcohol/Drug)  Mental Health (including psychological testing)  HIV-RELATED INFORMATION (INCLUDING AIDS TESTING)  HIV-RELATED INFORMATION (INCLUDING AIDS TESTING)  Genetic Information (Including Psychological testing)  This form Does Not authorize re-disclosure of medical information has been Disclosed through records that are protected by federal Law, or Mental Health records Protected by State Law, Further Disclosure is prodificed without specific written consent of The Individual or as otherwise Premitted by Such Law And/or Regulations. A general authorization is not sufficient for these purposes.  Signature of Patient (if 18 years of age or older):  Date  Date		
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Signature of Parent or Legal Representative (if applicable):  Relationship to Patient, if not signed by Patient:  In addition to the authorization provisions above, I authorize the release and re-disclosure of all information, data, notes, records, reports, and all other documents to the Requestor, its consultants, experts, agents and/or other counsel relating to:  Substance Abuse (Alcohol/Drug)  Mental Health (including psychological testing)  HIV-related information (including AIDS testing)  Genetic Information  Genetic Information  Genetic Information  This form does not authorize re-disclosure of medical information beyond the Limits of this consent. Where alcohol/drug abuse information has been disclosed through records that are protected by federal Law, or mental health records through records that are protected by State Law, or mental health records sprotected by State Law, Further disclosure is prohibited written consent of the individual or as otherwise permitted by such Law and/or regulations. A general authorization is not sufficient for these purposes.  Signature of Parent or Legal Representative (if applicable):  Date  Date	Requestor at the address listed above. I understand that conditioned upon signing this authorization. I understa	at treatment, payment, enrollment or eligibility for benefits may not be and that the Requestor may redisclose this information, and if re-disclosed, the
Relationship to Patient, if not signed by Patient:  In addition to the authorization provisions above, I authorize the release and re-disclosure of all information, data, notes, records, reports, and all other documents to the Requestor, its consultants, experts, agents and/or other counsel relating to:  Substance Abuse (Alcohol/Drug)  Mental Health (including psychological testing)  HIV-related information (including AIDS testing)  Genetic Information  Genetic Information  This form does not authorize re-disclosure of medical information beyond the Limits of this consent. Where alcohol/drug abuse information has been disclosed through records that are protected by federal law, or mental health records protected by state law, further disclosure is prohibited without specific written consent of the individual or as otherwise permitted by such law and/or regulations. A general authorization is not sufficient for these purposes.  Signature of Patient (if 18 years of age or older):  Date  Date  Date	Signature of Patient (if 18 years of age or older):	Date
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SUBSTANCE ABUSE (ALCOHOL/DRUG) MENTAL HEALTH (INCLUDING PSYCHOLOGICAL TESTING) HIV-RELATED INFORMATION (INCLUDING AIDS TESTING) GENETIC INFORMATION GENETIC INFORMATION  THIS FORM DOES NOT AUTHORIZE RE-DISCLOSURE OF MEDICAL INFORMATION BEYOND THE LIMITS OF THIS CONSENT. WHERE ALCOHOL/DRUG ABUSE INFORMATION HAS BEEN DISCLOSED THROUGH RECORDS THAT ARE PROTECTED BY FEDERAL LAW, OR MENTAL HEALTH RECORDS PROTECTED BY STATE LAW, FURTHER DISCLOSURE IS PROHIBITED WITHOUT SPECIFIC WRITTEN CONSENT OF THE INDIVIDUAL OR AS OTHERWISE PERMITTED BY SUCH LAW AND/OR REGULATIONS. A GENERAL AUTHORIZATION IS NOT SUFFICIENT FOR THESE PURPOSES.  Signature of Parent or Legal Representative (if applicable):  Date	Relationship to Patient, if not signed by Patient:	
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