PRECISION ORTHOPAEDIC SPECIALTIES, INC.

AUTHORIZATION FOR DISCLOSURE OF PROTECTED HEALTH INFORMATION (PHI)

Name: __ **Date of Birth:**

Last **First** **Middle Initial**

Day Phone: **Last Four Digits of SSN: XXX-XX-**

I voluntarily authorize the release of my personal health information as indicated/described below**.** I understand that the information released/obtained may contain information concerning treatment for ***a psychiatric condition, a sexually transmitted disease, alcohol or drug treatment/abuse, HIV test results, an AIDS diagnosis or related condition and past medical history, and I expressly consent to such release.***

Release Instructions: Please indicate which facility you would like to release information FROM and who you want the information sent TO:

CHECK ONE: ☐ **FROM** ☐ **TO**	☐ **FROM** ☐ **TO**
Precision Orthopaedic Specialties, Inc. Albert Dunn, D.O.; Laszlo Harmat, D.O.; George Kellis, M.D.; Michael Kellis, D.O.; Mark Mendeszoon, DPM, Kraig Solak, D.O., Greg Sarkisian, D.O. 150 Seventh Avenue, Suite 200 Chardon, OH 44024 Phone: 440-285-4999 Fax: 440-285-4996	**Physician/Facility Name, Phone & Fax Numbers:**

Purpose of Disclosure: □ Medical Care □ At the request of the patient □ Legal □ Personal Use

Information to be released:

- ❑ Entire record of treatment provided □ Billing Records □ X-RAY Films □ MRI Disc(s)
- ❑ Only the following records (i.e. related to Workers Comp; MVA or specific body part):

- ❑ Only release for these treatment date(s) _____TO_____

Term: This Authorization will remain in effect for **ONE YEAR** if nothing is checked below.

- ❑ From the date of this Authorization until _____ , 201 ____
- ❑ Until the following event occurs (i.e. lawsuit settled): _____

Revocation: I understand that this Authorization will remain in effect until the term of this Authorization expires unless revoked by me in writing for any reason at any time and presented to PRECISION's Privacy Officer at the address listed below. Any revocation will not apply to information already released by my health care provider in response to this Authorization. I understand that I may refuse to sign or may revoke this Authorization and that such refusal or revocation will not affect the commencement, continuation or quality of my treatment by PRECISION.

Redisclosure: I understand that after my personal health information is released, my health information may be re-disclosed by the recipient and may no longer be protected by law. I hereby release PRECISION and its staff from any/all legal liability that may arise from the authorized disclosure of my personal health information.

I understand that I am entitled to a copy of this Authorization and that a copy of this Authorization is as valid as the original.

Questions: I may contact the PRECISION Privacy Officer for answers to my questions about the privacy of my protected health information at 150 Seventh Avenue, Suite 200, Chardon, OH 44024, or by telephone at (440) 285-4999 Ext. 254.

Signature of Patient/Legal Representative Date Signature of Witness for Legal Representative

If Authorization is signed by someone other than patient, documents verifying signer's legal authority (e.g. Power of Attorney or Death Certificate) **MUST** accompany this Authorization. Exception: Parent signing for minor patient who certifies there is no court order prohibiting parent from obtaining the requested records. If patient is deceased, executor/administrator appointment of patient's estate or nearest relative may sign.

Print Name of Legal Representative Legal Status/Relationship (e.g.: Parent/Guardian/Executor)

OFFICE USE: □ **Hand Delivered** □ **Mailed** □ **Faxed** □ **Emailed Date:** **By:**