



Southwest Sports Medicine
& Orthopaedic Surgery Clinic, LTD

□ Dr. Angelo J. Mattalino

AUTHORIZATION TO USE OR DISCLOSE PROTECTED HEALTH INFORMATION

I, _____ authorize *Southwest Sports Medicine* to disclose the following information from the health records of:

Patient Identification:

_____		_____	
Patient's Name		Date of Birth	
_____		_____	_____
Address		Home Phone	Other Phone
_____		_____	_____
City		State	Zip Code

Date of Service: From: _____ To: _____

Information Requested:

- | | |
|--|---|
| <input type="checkbox"/> Billing Record | <input type="checkbox"/> Operative Report(s) |
| <input type="checkbox"/> Progress Note(s) | <input type="checkbox"/> Pathology Report (s) |
| <input type="checkbox"/> Consultation(s) | <input type="checkbox"/> X-Ray/MRI CD(s) |
| <input type="checkbox"/> History & Physical(s) | <input type="checkbox"/> X-Ray/MRI Report(s) |
| <input type="checkbox"/> Entire/Medical Chart(s) | <input type="checkbox"/> Other: _____ |

Purpose:

- | | | |
|--|--|---|
| <input type="checkbox"/> Self | <input type="checkbox"/> Continuing Medical Care | <input type="checkbox"/> Attorney Request |
| <input type="checkbox"/> Other (specify reason): _____ | | |

Information to be sent to:

_____		_____	
Name		Phone Number	
_____		_____	_____
Address		City	State Zip Code

I authorize *Southwest Sports Medicine* to release medical information regarding treatment and/or outpatient care. I understand that the information may include psychological or psychiatric impairment(s), drug abuse, alcoholism, infections, or contagious disease information, including HIV (Human Immunodeficiency Virus), and AIDS (Acquired Immunodeficiency Syndrome) related confidential information.

I understand that I may revoke this authorization of release of medical at anytime, except to the extent action has been taken in reliance on it and that in any event this authorization will expire 90 days from the state signed and/or as specified _____.

I understand that, if this information is disclosed to a third party, the information may no longer be protected by the state, federal regulation and may be re-disclosed by the person or organization that received the information.

I may refuse to sign this authorization form and understand that *Southwest Sports Medicine* will not condition or deny treatment on my signing this authorization.

I release *Southwest Sports Medicine*, its employees and medical staff members from any legal responsibility for the disclosure of the above information to the extent indicated and authorized herein.

Signature of Patient or Guardian

Date

Signature of person authorized to sign in lieu of part/Relationship

Date