OCH ORTHOPEDIC CENTER
P.O. DRAWER 1326
STARKVILLE, MS 39759
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AUTHORIZATION FOR DISCLOSURES OF PROTECTED HEALTH INFORMATION

Patient Name:_____ Patient Number:_____

Date of Birth:_____

I hereby authorize **OCH Orthopedic Center** to use or disclose my protected health information covered under privacy regulations issued pursuant to the Health Insurance Portability and Accountability Act of 1996 to:_____
for the following purposes:_____

List dates and information to be used or disclosed:_____
_____
_____

CONDITIONS:

- The patient agrees to authorize the above named individuals/organization to access his/her confidential healthcare information only for the purpose listed above.
- The information authorized to be released will not be covered under the federal privacy laws.
- **OCH Orthopedic Center** will provide the patient/organization with a copy of the confidential healthcare information for which this authorization is being sought.
- The patient is voluntarily signing this authorization.
- The patient reserves the right to refuse to sign this authorization.
- The patient reserves the right to revoke this authorization at any time. This revocation must be in writing and shall not be effective with respect to any use or disclosure made by the Hospital in reliance on this Authorization prior to the date of the Hospital's receipt of my revocation.
- The patient may receive a copy of the signed Authorization.

This Authorization will expire on the following date or event:_____

I certify that I am the Patient listed above or a person authorized to permit release of records on Patient's behalf. I hereby release **OCH Orthopedic Center** from any liability arising in connection with the use or disclosure of my protected health information pursuant to this Authorization.

Patient/Legal Representative:_____
Date:_____

Basis of authority to sign for patient:_____