NOTICE OF PRIVACY PRACTICES AND AUTHORIZATION FOR RELEASE OF PROTECTED HEALTH INFORMATION

I HAVE REVIEWED A COPY OF THE "NOTICE OF PRIVACY PRACTICES" FROM THE ORTHOPAEDIC CENTER OF CORPUS CHRISTI, WHICH EXPLAINS HOW MY MEDICAL INFORMATION WILL BE USED AND DISCLOSED. I UNDERSTAND THAT I AM ENTITLED TO RECEIVE A COPY OF THIS DOCUMENT.

SIGNATURE OF PATIENT ______________________________ DATE_________________________

Representative's authority to sign for this patient
(i.e. parent, guardian, power of attorney, etc.)

RELEASE OF HEALTH INFORMATION

IF YOU WISH TO HAVE YOUR SPOUSE, FAMILY MEMBER, COACH/TRAINER OR ANY OTHER PERSON HAVE ACCESS TO YOUR PROTECTED HEALTH INFORMATION, PLEASE PROVIDE US WITH THE NAME(S) OF THE PERSON(S) OR ENTITY. IF NO ONE, PLEASE WRITE "NO ONE".

NAME(S) _______________________________________ RELATIONSHIP_____________________

PLACE AN (X) NEXT TO THE INFORMATION YOU ARE AUTHORIZING TO BE RELEASED TO THE ABOVE NAMED PERSON

_____ANY AND ALL INFORMATION

_____LAB TEST RESULTS

_____MEDICAL RECORDS

_____FINANCIAL HISTORY

_____APPOINTMENT DATE AND TIME

SIGNATURE OF PATIENT _____________________________________

Representative's authority to sign for this patient
(i.e. parent, guardian, power of attorney, etc.)

BY SIGNING THIS FORM, I AUTHORIZE THE ORTHOPAEDIC CENTER OF CORPUS CHRISTI TO USE AND DISCLOSE THE PROTECTED HEALTH INFORMATION AS DESCRIBED ABOVE. THIS AUTHORIZATION SHALL BE IN FORCE AND EFFECTIVE, UNTIL I REVOKE THIS AUTHORIZATION IN WRITING TO THE COMPLIANCE OFFICER LISTED BELOW.

LYLIA F. LEAL
COMPLIANCE OFFICER
6118 PARKWAY DRIVE
CORPUS CHRISTI, TEXAS 78414