Name:
DOB:
Chart:
Age:
Date:

ORTHOPAEDIC & SPORTS CLINIC

Authorization for use or Disclosure of Protected Health Information

I authorize my physician and/ or adminstrative and clinical staff of Orthopaedic & Sports Clinic to disclose general medical information and other protected health information to the following persons and/ or entities listed below. If no one is listed below, protected health care information will not be disclosed except in those situations described in the Notice fo Privacy Practices of Orthopaedic & Sports Clinic.

Name and relationship of person you wish to allow access - for example, your spouse, child, sibling, neighbor, caretaker, clergy, or close friend:

Name of Person or Entity	Relationship	Phone Number

This authorization to use and disclose health information is being submitted by my request and shall be in force and effect until revoked in writing by me.

I understand that information used or disclosed pursuant to this authorization may be disclosed by Scott G. Petrie MD and his staff and may no longer be protected by federal and state law.

I understand that I have the right to revoke this authorization, in writing at any time by sending such written notification to the privacy officer at 1014 W. St. Clare Blvd., Suite 1020, Gonzales, LA 70737. I understand information that is disclosed under this authorization may be disclosed again by the person or organization to which it is sent. The privacy of this information may not be protected under the federal privacy regulations.

Regardless of whether you provide us with this authorization, we will provide you with medical services or conduct payment operations.

Signature of Patient or Personal Representative

Date

Print Name of Patient or Personal Representative

Description of Personal Representative's Authority

Send Correspondence to:
Privacy Officer
1014 W. St. Clare Blvd. Ste. 1020
Gonzales, LA 70737