PHWE | PROLIANCE HAND, WRIST & ELBOW PHYSICIANS
WORK AGAIN, PLAY AGAIN!

Authorization for Proliance Surgeons, Inc., P.S. to Use or Disclose My Health Care Information

Patient name: _____ Date of birth: _____

I. My Authorization

You may use or disclose the following health care information (check all that apply):

- ☐ All health care information in my medical record
- ☐ Health care information in my medical record relating to the following treatment or condition:

_____

- ☐ Health care information in my medical record for the date(s):_____
- ☐ Other (e.g., X rays, bills), specify date(s):_____

You may use or disclose health care information regarding testing, diagnosis, and treatment for (check all that apply):

- ☐ HIV (AIDS virus)
- ☐ Sexually transmitted diseases
- ☐ Psychiatric disorders/mental health
- ☐ Drug and/or alcohol use

You may disclose this health care information to:

Name (or title) and organization: _____

Address: _____

City: _____ State: _____ Zip: _____

Phone Number: _____ Fax: _____

Reason(s) for this authorization (check all that apply):

- ☐ at my request
- ☐ other (specify):

_____

- ☐ check only if practice requests the authorization for marketing purposes
- ☐ check only if practice will be paid or get something of value for providing health information for marketing purposes
- ☐ This authorization ends: *(If disclosure is to a financial institution or employer of the patient for purposes other than payment, then as to those disclosures this authorization expires 90 days after signed, unless renewed.)*
- ☐ on (date):_____
- ☐ when the following even occurs: _____

II. My Rights

I understand I do not have to sign this authorization in order to get health care benefits (treatment, payment or enrollment). However, I do have to sign an authorization form:

- To take part in research study or
- To receive health care when the purpose is to create health care information for a third party.

I may revoke this authorization in writing. If I did, it would not affect any actions already taken by Proliance Surgeons, Inc., P.S. based upon this authorization. I may not be able to revoke this authorization if its purpose was to obtain insurance. Two ways to revoke this authorization are:

- Fill out a revocation form. A form is available from the practice or
- Write a letter to the practice.

Once health care information is disclosed, the person or organization that receives it may re-disclose it. Privacy laws may no longer protect it.

_____ _____

Patient or legally authorized individual signature | Date | Time

_____ _____

Printed name if signed on behalf of the patient | Relationship (parent, legal guardian, personal representative)

Fax: 425.820.8975 Phone Number: 425-823-4224