ENGLEWOOD SPORTS MEDICINE ORTHOPAEDIC SURGERY, P.C.

# AUTHORIZATION TO USE OR DISCLOSE PROTECTED HEALTH INFORMATION (PHI)

## GENERAL PURPOSES

| PATIENT'S NAME | VERIFICATION OF IDENTITY (Driver's License, ID Card, Passport, etc.) | |
|---|---|---|
| ADDRESS | | BIRTH DATE |
| EMAIL ADDRESS | PHONE / CELL NUMBER | |

**▼ Complete the following only if the person authorizing the use or disclosure is not the patient. ▼**

| LEGAL REPRESENTATIVE'S NAME | VERIFICATION OF IDENTITY | |
|---|---|---|
| ADDRESS | VERIFICATION OF AUTHORITY | RELATIONSHIP TO PATIENT |
| EMAIL ADDRESS | PHONE / CELL NUMBER | |

I request and authorize _____ to release healthcare information of the patient named above to: **Englewood Sports Medicine Orthopaedic Surgery, P.C.**
**370 Grand Avenue, Suite 100**
**Englewood, NJ 07631**

THIS REQUEST AND AUTHORIZATION APPLIES TO:

◯ HEALTHCARE INFORMATION RELATING TO THE FOLLOWING TREATMENT, CONDITION, OR DATES:

◯ ALL HEALTHCARE INFORMATION

◯ OTHER:

**I FURTHER AUTHORIZE** THE DISCLOSURE OF THE FOLLOWING INFORMATION, WHICH MAY BE INCLUDED IN THE PROTECTED HEALTH INFORMATION LISTED ABOVE. (CHECK ALL THAT ARE APPROVED.)

◯ MENTAL HEALTH ◯ SUBSTANCE ABUSE ◯ STD / HIV / AIDS ◯ GENERIC DATA ◯ RECORDS CREATED BY NON-ESMOS PROVIDERS

- I understand that, by federal law, Englewood Sports Medicine Orthopaedic Surgery, P.C. (ESMOS) may not use or disclose protected health information (PHI) without authorization except as provided in ESMOS Notice of Privacy Practices. By signing this Authorization, I am giving permission for the use or disclosure of the PHI described above. I hereby release ESMOS and its employees from any and all liability that may arise from the release of information as I have directed.
- I understand that I have the right to revoke this Authorization at any time, if I do so in writing, and address it to the person or institution named above. The revocation will not apply to any information already released as a result of this authorization.
- I understand that I may refuse to sign this Authorization, and that the institutions or individuals named above cannot deny or refuse to provide treatment, payment, enrollment in a health plan or eligibility for benefits if I refuse to sign.
- I understand that information disclosed pursuant to this Authorization may no longer be protected by federal health information privacy laws and could be re-disclosed by the person or agency that receives it.
- I understand that I may be charged a fee of up to $1.00 per page (plus applicable tax and handling) for every page copied and that this fee is within the limits allowed by New Jersey law.

| THIS AUTHORIZATION EXPIRES WHEN PATIENT IS DISCHARGED ROM CARE.<br>DATE OR EVENT: | THIS AUTHORIZATION MAY BE USED TO DISCLOSE THE SAME TYPE(S) OF HEALTH INFORMATION DESCRIBED ABOVE, WHICH MAY BE CREATED IN THE FUTURE, UNTIL THE EXPIRATION DATE: ◯ YES ◯ NO |
|---|---|

| SIGNATURE OF PATIENT OR LEGAL REPRESENTATIVE | DATE |
|---|---|