AUTHORIZATION OF DISCLOSURE OF MEDICAL INFORMATION

I hereby authorize Performance Orthopaedics & Sports Medicine to use and/or disclose my protected health information which specifically identifies me, or which can reasonably be used to identify me to carry out my medical treatment, billing or claims payment and other health care operations.

I understand that any and all records, whether written, oral or in electronic format are confidential and cannot be disclosed for reasons outside of treatment, payment or healthcare operations. I understand that I have been provided with access to either review and/or receive a copy of "Notice of Privacy Practices" for Performance Orthopaedics & Sports Medicine which more fully describes the uses and disclosures. I understand that I have the right to request restrictions as to how my health information may be used or disclosed to carry out treatment, payment or healthcare operations and that the office and I must agree on the use and disclosure of my protected health information. I understand that Performance Orthopaedics & Sports Medicine has the right to change its privacy policies and that I can receive such changed notices upon request.

I understand if I would like to release my PHI to another doctor or facility, I will be required to fill out a separate form to request my records.

A photocopy or fax of this consent is as valid as this original. I understand that I may revoke this consent, in writing, except where disclosures have already been made in reliance.

_____ _____

Signature of Patient or Legally Authorized Representative Date

HIPAA AUTHORIZATION TO DISCUSS YOUR MEDICAL INFORMATION

I give permission to Performance Orthopaedics & Sports Medicine to release my private health information, including appointment day/time, to the following person(s); spouse, family member, etc. I understand that I am not required to list anyone, and I may change this list at any time in writing.

(Please specify the type of information that may be disclosed, such as lab/imaging test, appointment information, prescription information, bill information, etc. You may indicate "All" if appropriate. If you do not list anyone, we are only able to discuss your treatment and/or account matters with you. No one may call on your behalf.

Name	Relationship	Phone number	Type of Information

The duration of this authorization is one year or until written permission is accepted for withdrawal. I understand that request for health information from persons not listed on this form will require my specific authorization prior to the disclosure of any health information.

Printed Name of Patient:_____

_____ _____

Signature of Patient or Legally Authorized Representative Relationship to patient Date