University Orthopaedic Clinic and Spine Center

Policy 2

AUTHORIZATION TO VERBALLY DISCLOSE or PICKUP PERSONAL HEALTH INFORMATION

PATIENT NAME:___________________________DOB:________________Chart #:________________

I (We) the undersigned patient and/or responsible party hereby authorize University Orthpaedic Clinic, P.C. (UOC), it's physicians, agents, employees or contractors to speak with and disclose information to the person or persons indicated below: This does not include or replace the HIPAA Compliant Authorization for Medical Records form needed for requests of medical records by third parties. By signing below, you hereby authorize UOC to use or disclose information about yourself (or another person for whom you have the authority to sign) that is protected under federal law, for the sole purpose and time period described below.

Please disclose information only to myself ☐ If you check this box, do not complete the next section.

If you want certain individuals to disclose/pickup information, please complete the section below.

You do not have to list your Primary Care Physician. We will disclose to them.

__________________________________ ☐ Test Results ☐ Pick Up Prescriptions
Name Relationship to Patient ☐ Financial Info ☐ Medical Information

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Sensitive Privileged Information: I authorize release of information relating to AIDS or HIV, Psychiatric Care and/or Psychological Assessment, Testing and Treatment for Alcohol and/or Drug Abuse. _____YES _____NO

This authorization will expire at the end of the calendar year of your signature below unless you specify an earlier termination. You must complete a new authorization each year. Use or disclosure of the PHI will not result in remuneration to us. This information is protected under federal law, and you have the right to revoke this authorization in writing. Please be advised, however that any revocation will be effective only to the extent we have not already taken action in reliance on your authorization. By signing below, you recognize that the protected health information used or disclosed pursuant to this authorization may be subject to re-disclosure by the recipient of this disclosure and may no longer be protected under federal law. We will not condition treatment based on your authorization. You may refuse to sign the authorization. University Orthopaedic Clinic, P.C. will not condition treatment, payment, enrollment in the health plan, or eligibility of benefits on the individual's providing authorization for the requested use or disclosure.

Medicare and Advantage Patients If you have enrolled in the Medicare PPO Plan in Alabama, called Blue Advantage, OR if you have Traditional Medicare and are 65 years or older, your plan requires that providers have information on file regarding whether you have an Advance Directive or not. Therefore, we ask that you complete the information below.

☐ No, I do not have an Advance Directive. ☐ Yes, I do have an Advance Directive. The person elected to make those decisions for me is ____
Name Relationship to Patient Phone Number

____
Patient Signature or Personal Representative Date

REV: 07/21/2016