Authorization to Discuss Medical Information

I hereby authorize Orthopaedic Associates of Miami Lakes to use and/or disclose the specific information described below, only for the purposes and/or parties listed below.

Description of the specific information to be discussed:

_____ Appointment: Date & Time(s) _____ Diagnosis _____ X-Ray Results _____

_____ Medications _____ Lab Test/Results _____ Summary of Medical Records _____

_____ Care Plan _____ Other (Specify): _____

Indicate Confidential Information:

Mental Health _____ HIV Information _____ Alcohol/Drug Information _____

Patient Name: _____

Date of Birth: _____

Information to be given to:

Name: _____

Relationship: _____

Address: _____

Phone/Fax: _____

This authorization shall remain in effect from the date signed below until (Please check one):

☐ NO EXPIRATION DATE ☐ _____ (Specify expiration date)

I understand that:

- I may inspect or copy the protected health information to be used or disclosed.
- I may revoke this authorization in writing by contacting your office.
- This authorization is giving Orthopaedic Associates of Miami Lakes the right to discuss my medical information with the above mentioned.
- Information used or disclosed pursuant to the authorization may be subject to re-disclosure by the recipient and no longer be protected by the HIPAA.
- I may refuse to sign this authorization and you will not condition treatment or payment providing this authorization (except to the extent that the authorization is for research-related treatment, in which case you may refuse to provide that research-related treatment).

Signature: _____ Date: _____

Signature of Patient's Authorized Representative: _____ Date: _____