SOUTHERN ORTHOPAEDICS & SPORTS MEDICINE
3231 Glynn Avenue | Brunswick, GA 31520 | 912.265.9006

HIPAA AUTHORIZATION FORM

I authorize Southern Orthopaedics & Sports Medicine PC to use and disclose my following protected health information (PHI) listed below for the purpose(s) listed elsewhere on the page.

_____

_____

Name of entity or person(s) to receive information:

Name: _____ Relationship to you: _____

Date of Birth: _____ Primary Phone #: _____

Name: _____ Relationship to you: _____

Date of Birth: _____ Primary Phone #: _____

Describe how the PHI will be used or disclosed, such as date of service, type of service, level of detail to be released origin of information, etc.

_____

_____

This PHI is being used or disclosed for the following purposes: (*List specific purposes here.*)

This authorization shall be in force and effect until (specify date or event) _____, at which time this authorization to use and disclose this PHI information expires. ("*End of the research study" and "none" is acceptable for authorization for research purposes.)*

I understand that I have the right to revoke this authorization, in writing, at any time by sending such written notification to the practice's Privacy Officer at 3231 Glynn Avenue, Brunswick, GA (or by e-mail address). I understand that a revocation is not effective to the extent that my Physician has relied on the use or disclosure of the PHI or if my authorization was obtained as a condition of obtaining insurance coverage and insurer has a legal right to contest a claim.

I understand that information used or disclosed pursuant to this authorization may be disclosed by the recipient and may no longer be protected by federal or state law. The use or disclosure requested under this authorization may result in direct or indirect remuneration to the Physician from a third party.

_____ _____

Signature of Patient or Personal Representative Date

_____ _____

Print Name of Patient or Personal Representative Description of Personal Representative's Authority

(Provide a copy of this form to the patient.)