AUTHORIZATION FOR USE AND DISCLOSURE OF PROTECTED HEALTH INFORMATION

I hereby authorize Premier Orthopaedic & Sports Medicine Associates, LTD ("Covered Entity") to release the health information described below of myself or _____ to:

Recipient Name: _____
Relationship of Recipient to me or the individual named above
Recipient Address: _____
Recipient Phone #: _____

Specific Documents/Information I authorize to be released:

☐ All General Medical Initial _____ ☐ Alcohol/Substance Abuse Initial _____

☐ Mental Health Initial _____ ☐ AIDS/HIV Initial _____

☐ OTHER: (please specify, including dates of treatment and/or names of providers where appropriate) Initial _____

Purpose of Disclosure (explain or indicate "at the request of the individual"):

I understand that the terms of this Authorization are governed by the Health Insurance Portability and Accountability Act of 1996, Public Law 104-191 ("Original HIPAA"), as amended by the Health Information Technology for Economic and Clinical Health Act ("HITECH", and collectively with Original HIPAA, the "HIPAA Statute"), along with regulations promulgated by the Secretary of the Department of Health and Human Services under the HIPAA Statute, (collectively the "HIPAA Rules" and together with the HIPAA Statute, collectively, "HIPAA"), as well as any other applicable laws concerning the privacy and security of health information.

I understand that I have the right to revoke this Authorization, at any time prior to Covered Entity's compliance with the request set forth herein, provided that the revocation is in writing. I further understand that additional information relating to the exceptions to the right to revoke and a description of how I may revoke this Authorization is set forth in the Covered Entity's Notice of Privacy Practices. I understand that any revocation must include my name, address, telephone number, date of this Authorization and my signature and that I should send it to:

Name of Covered Entity: Premier Orthopaedic and Sports Medicine Associates, LTD
Address: 3809 West Chester Pike, Suite 150
City, State Zip: Newtown Square, PA 19073
Attention: Privacy Officer

I understand that I am not required to sign this Authorization and that the Covered Entity may not condition treatment on my execution of this Authorization.

I understand that the information used or disclosed pursuant to this Authorization may be subject to redisclosure by the Recipient listed above and, in that case, will no longer be protected by HIPAA.

This Authorization expires:
- ☐ One (1) year from date of authorization as set forth below.
- ☐ Upon Covered Entity's release of the information described above.
- ☐ _____days after the Date of Authorization, as set forth below.

I hereby acknowledge receipt of a copy of this Authorization.

_____ _____ _____
Patient Name (Printed) *Signature of Patient/Personal Representative* *Date of Authorization*