PATIENT AUTHORIZATION FOR USE AND DISCLOSURE OF PROTECTED HEALTH INFORMATION

By signing this authorization, I authorize Northern Virginia Orthopaedic Specialists (NVOS) to use and/or disclose certain protected health information (PHI) about me to ____. This authorization permits NVOS to use and/or

Name of entity to receive this information

disclose the following individually identifiable health information about me (specifically describe the information to be used or disclosed, such as date(s) of services, type of services, level of detail to be released, origin of information, etc.):

____

____.

The information will be used or disclosed for the following purpose:

____.

If requested by the patient, purpose may be listed as "at the request of the individual."
The purpose(s) is/are provided so that I can make an informed decision whether to allow release of the information. This authorization will expire on ____________________________________.

Expiration Date or Defined Event

I do not have to sign this authorization in order to receive treatment from NVOS. In fact, I have the right to refuse to sign this authorization. When my information is used or disclosed pursuant to this authorization, it may be subject to redisclosure by the recipient and may no longer be protected by the federal HIPAA Privacy Rule. I have the right to revoke this authorization in writing except to the extent that the practice has acted in reliance upon this authorization. My written revocation must be submitted to the Privacy Official at:

Northern Virginia Orthopaedic Specialists
Attn: Privacy Officer
8644 Sudley Rd, Suite 308
Manassas, Virginia 20110

Signed by:_________________________________
Signature of Patient

_________________________________ ____________
Print Name of Patient Date

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For Office Use Only

Chart Number: