

**Orthopedic Associates of Lancaster**  
170 North Pointe Boulevard  
Lancaster, PA 17601-4132  
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**AUTHORIZATION FOR USE OR DISCLOSURE OF HEALTH INFORMATION**

Patient name: \_\_\_\_\_ Date of birth: \_\_\_\_\_  
Please print

I hereby authorize the use and disclosure of individually identifiable health information relating to me, which is called protected health information under a federal health privacy law, as described below:

**Persons or Organization authorized to disclose health information:** (include contact information)

\_\_\_\_\_

**Persons or Organization authorized to receive health information :** (include contact information)

\_\_\_\_\_

**Specific Description of the information to be used or disclosed including the dates of service(s):**

\_\_\_\_\_

\_\_\_\_\_

**The protected health information will be used and/ or disclosed for the following purposes:**

( ) At the request of the individual (check box if applicable)

( ) Other: \_\_\_\_\_

- I understand that if the person or organization that receives this information is not a health plan or health care provider covered by the federal privacy regulations, the released information may be re-disclosed by the recipient and may no longer be protected by federal or state law.
- I understand that I may revoke this authorization at any time by notifying Orthopedic Associates of Lancaster in writing. However, if I choose to do so, I understand that my revocation will not affect any actions taken by Orthopedic Associates of Lancaster before receiving my revocation.
- I understand that I may refuse to sign this authorization and that my refusal to sign in no way affects my treatment, payments, enrollment in a health plan or eligibility for benefits.

**This authorization expires on \_\_\_\_\_, or the date the following event occurs:** \_\_\_\_\_

\_\_\_\_\_

(describe the event or write "not applicable")

Signature of patient: \_\_\_\_\_ Date: \_\_\_\_\_

Patient's Social Security number: \_\_\_\_\_

For Personal Representative of the patient (if applicable):

Print name of Personal Representative: \_\_\_\_\_

Relationship of Personal Representative: \_\_\_\_\_

(parent, guardian, etc.)

Signature of Personal Representative: \_\_\_\_\_

Date: \_\_\_\_\_