SOUTHERN INDIANA ORTHOPEDICS
The Strength of Experience

AUTHORIZATION FOR USE OR DISCLOSURE OF PROTECTED HEALTH INFORMATION

1. I hereby authorize Southern Indiana Orthopedics, Inc., to release or obtain protected health information in my medical record:

Receive From: _____		Send To: _____	
Address: _____		Address: _____	
City, State, Zip: _____	**OR**	City, State, Zip: _____	
Telephone #: _____		Telephone #: _____	
Fax #: _____		Fax #: _____	

2. Release the following health information:
   _____ Entire medical record _____
   _____ The following specific portions of the medical record:
   For the period of _____ to _____
   _____ X-rays/MRI of _____
   For the period of _____ to _____

3. This protected health information is being used or disclosed for the following purposes:
   Insurance Claim: _____ Continuity of Care: _____ Personal: _____
   Other: _____

4. This authorization shall be in force and effective until _____ (specify date or event that relates to the patient or the purpose of the use or disclosure), at which time this authorization to use or disclose this protected health information expires.

5. I understand that I have the right to revoke this authorization, in writing, at any time by sending such written notification to Southern Indiana Orthopedics, Inc. I understand that a revocation is not effective to the extent that Southern Indiana Orthopedics, Inc., has relied on the use or disclosure of the protected health information.

I understand that information used or disclosed pursuant to this authorization may be subject to redisclosure by the recipient and may no longer be protected by Federal or state law.

Southern Indiana Orthopedics, Inc., will not condition my treatment, payment, enrollment in a health plan, or eligibility for benefits (if applicable) on whether I provide authorization for the requested use or disclosure.

I acknowledge by signing this authorization that there may be a charge for copies of my health information as allowed by law.

I understand I have the right to:

- Inspect or copy the protected health information to be used or disclosed as permitted under Federal law (or state law to the extent the state law provides greater access rights).
- Refuse to sign this authorization.
- Receive a signed copy of this authorization.

_____ _____
Name of Patient Date of Birth

_____ _____
Signature of Patient or Personal Representative Date

_____
If Personal Representative, Relationship to Patient

_____
Name of Person Who Will Be Picking Up Medical Records if Other Than Patient

**Please mail to 4665 North US 31, Columbus, IN 47201.

Southern Indiana Orthopedics, Inc., complies with applicable Federal civil rights laws and does not discriminate on the basis of race, color, national origin, age, disability, or sex.