

AUTHORIZATION FOR USE/DISCLOSURE OF HEALTH INFORMATION

Patient Name: _____ Date of Birth: _____ Patient #: _____

Authorization for Use/Disclosure of Information: I voluntarily consent to authorize my health care provider Clinton M. Ray Orthopedics & Sports Medicine, LLC office of Clinton M. Ray, MD and Jeffrey D. Lawler, MD to use or disclose my health information during the term of this Authorization to the recipient(s) that I have identified below.

Recipient(s): I authorize the release of my health care information to be released to the following recipient(s):

Name: _____

Phone: _____ Fax: _____

_____ Clinton M. Ray, M.D. or Jeffrey D. Lawler, M.D. 1419 Hamric Drive, Suite 201 Oxford, AL 36203
Phone: (256) 241-4842 Fax records to: (256) 241-3254

Purpose: I authorize the release of my health care information to be released for the following purpose:

(Note: "at the request of the patient "is sufficient if the patient is initiating this Authorization)

Information to be disclosed: I authorize the release of the following information: (check all that apply)

_____ All of my health information that the provider has in his/her possession, including information relating to any medical history, mental or physical condition and any treatment received by:

Name or Facility: _____

_____ Only the following records or types of health information: _____

Term: I understand that this Authorization will remain in effect:

_____ From the date of this Authorization until the _____ day of _____, 20____.

_____ Until the Provider fulfills this request.

_____ Until the following event occurs: _____

Special Disclosure: _____ I **DO NOT** authorize the release of information pertaining to HIV test results, psychotherapy notes, drug or alcohol treatment or use of mental records.

Redisclosure: I understand that my health care provider cannot guarantee that the recipient will not redisclose my health information to a third party. The third party may not be required to abide by this Authorization or applicable federal and state law governing the use and disclosure of my health information.

Signature of Patient or Guardian

Relationship to Patient

Date

Signature of Witness

Date