



Concord Orthopaedics Professional Association (COPA)
Authorization To Use Or Disclose My Protected Health Information (PHI)

Patient Name: _____ **DOB:** _____ **Phone #** _____

I authorize COPA to **USE (REQUEST)** or **DISCLOSE (RELEASE)** the following Protected Health Information, by any acceptable means, including fax or e-mail:

- | | Physician(s): | Date (s) of Service or Relating to the Following Condition: |
|--|---------------|---|
| <input type="checkbox"/> Office Notes | _____ | _____ |
| <input type="checkbox"/> Operative Report | _____ | _____ |
| <input type="checkbox"/> Diagnostics | _____ | _____ |
| <input type="checkbox"/> X-Rays (films) | _____ | _____ |
| <input type="checkbox"/> Other | _____ | _____ |

FOR THE PURPOSE OF (Use/Request):

Continuity of Care-Requested of (need full name of physician or health care facility & complete address)

FOR THE PURPOSE OF (Disclose/Release):

- Personal Use - \$.50 per page**
- M.D. Appointment with:** _____ **on** _____
- W/C Labor Board Hearing:** _____

INSTRUCTIONS:

Mail to Concord Orthopaedics, 264 Pleasant Street, Concord, NH 03301 Attn: _____ or Fax to (603) 224-7815.

- Patient will pick up on:** _____
- Mail to patient @** _____
- Mail/ Fax to physician @** _____

- I understand that the information in my health records may include information relating to sexually transmitted disease, acquired immunodeficiency syndrome (AIDS), or human immunodeficiency virus (HIV). It may also include information about behavioral or mental health services, and treatment for alcohol or drug abuse.
- I understand that this authorization shall expire one year from its effective date, unless it is revoked prior to the expiration date.
- I understand that I have the right to revoke this Authorization by providing written notice to the attention of the HIPAA Privacy Officer at COPA. The revocation will be effective upon receipt except with respect to uses or disclosures made prior to receipt and in reliance upon this Authorization.
- I understand that once the requested information is disclosed pursuant to this Authorization, Concord Orthopaedics will no longer have control over the information and there is a potential that it may be re-disclosed by the recipient and may not be protected by the Privacy Rules under the Health Insurance Portability and Accountability Act.
- I understand that COPA can not require that I sign this Authorization as a condition to the provision of services.
- I am entitled to a copy of this signed Authorization Form upon request.

 Witness Signature

 Print Name of Witness

 Signature of Patient or Legal Representative

 Print name of Patient or Legal Representative & Relationship to Patient

 Date

Internal use only: Processed by: _____ Date: _____