



Nirschl Orthopaedic Center for Sports Medicine & Joint Reconstruction

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HIPPA Authorization Form

PF-3000 Standard Authorization of Use and Disclosure of Protected Health Information

Nirschl Orthopaedic Center for Sports Medicine & Joint Reconstruction

Information to Be Used or Disclosed

The information covered by this authorization includes your registration information and your medical records including but not limited to: medications, diagnostic test & lab results, x-ray, MRI, CT, bone scan findings, as well as past and current clinical examination, physical therapy findings and recommendations, charges, appointment times and dates. The information will be disclosed to assist in authorization and payment for services, to coordinate recommend medical care, pre-certification and authorization for prescribed care.

Persons to Whom Information May Be Disclosed

Information described above may be disclosed to: (Spouse, Children, Friend, Office Staff, etc.). Please include home work and cell phone numbers.

If we are unable to contact you or if there is an urgency or emergency, who may we contact?

Name of persons and relationship to the patient: _____

Name of organization: _____

This authorization remains effective unless revoked or terminated by the patient or the patient’s personal representative. Right to Terminate or Revoke Authorization. You may revoke or terminate this authorization by submitting a written revocation to Nirschl Orthopedic Clinic. You should contact the Privacy Officer to terminate this authorization.

Potential for Re-disclosure

Information that is disclosed under this authorization may be disclosed again by the person or organization to which it is sent. It may not be possible to ensure your right to the protection of the privacy of this information once Nirschl Orthopedic Clinic discloses it to another party.

Rights of the Individual

- You may inspect or copy information used or disclosed under this authorization.
- You may refuse to sign this authorization.

Refusing Authorization:

If you refuse to sign this authorization, Nirschl Orthopedic Clinic will not deny you any treatment except research-related treatment or treatment that you have requested for the purpose of disclosure to others, including:

Treatment conditioned on authorization

Signature of Patient/Guardian: _____ **Date:** _____

Please print patient/guardian name & relationship: _____

Authorization Revoked:
effective through / /