SAGINAW VALLEY BONE & JOINT CENTER PC
AUTHORIZATION TO RELEASE MEDICAL INFORMATION

I HEREBY AUTHORIZE MY PROVIDER, SAGINAW VALLEY BONE & JOINT CENTER, TO RELEASE ANY INFORMATION NECESSARY FOR MY COURSE OF TREATMENT.

_____ DATE: _____
PATIENT OR PERSONAL REPRESENTATIVE SIGNATURE
(OR PARENT IF PATIENT IS A MINOR)

IF YOU WANT ANYONE OUTSIDE THE MEDICAL FIELD OR YOUR INSURANCE COMPANY (SUCH AS SPOUSE, PARENT, CHILD OR FRIEND), TO COMMUNICATE WITH OUR OFFICE REGARDING YOUR HEALTH INFORMATION OR ACCOUNT, PLEASE FILL OUT THE RELEASE BELOW.

AUTHORIZATION FOR USE OR DISCLOSURE OF INFORMATION

I AUTHORIZE **SAGINAW VALLEY BONE & JOINT CENTER** TO USE OR DISCLOSE THE FOLLOWING PROTECTED HEALTH INFORMATION (ALL OR SPECIFY WHICH INFORMATION).

( ) ALL INFORMATION ( ) SPECIFIC INFORMATION: _____

_____

MY PROTECTED HEALTH INFORMATION MAY BE DISCLOSED TO: _____
(PLEASE FILL IN INDIVIDUAL(S) NAME)

_____

I UNDERSTAND THAT I HAVE THE RIGHT TO REVOKE THIS AUTHORIZATION AT ANY TIME IN WRITING. I UNDERSTAND THAT I HAVE THE RIGHT TO INSPECT OR SECURE MY PROTECTED HEALTH INFORMATION TO BE USED OR DISCLOSED AS PERMITTED UNDER FEDERAL LAW.

_____ DATE: _____
SIGNATURE OF PATIENT OR PERSONAL REPRESENTATIVE
(OR PARENT IF PATIENT IS A MINOR)

_____
DESCRIPTION OF PERSONAL REPRESENTATIVE'S AUTHORITY