Authorization to Use or Disclose Protected Health Information

I hereby authorize use, or disclosure, of the names individual's health information as described below.

Patient Name: _____ Date of Birth: _____ SSN #: XXX-XX-_____

Address: _____
Street Apt # City State Zip

Home Phone: _____ Work Phone: _____ Cell Phone: _____

Email Address: _____ ❒ This is not my personal email address. For this release only.

The following individual or organization is authorized to make the disclosure.

❒ OSMC, LLC

❒ Other (please specify) _____

This information may be disclosed to and used by the following individual or organization:

❒ OSMC, LLC

❒ Other (please specify) _____

Treatment Dates/Specific Injury or Condition: _____

Information to be released:

❒ Office Chart Notes
❒ MRI Reports
❒ Operative Reports
❒ X-Ray Reports
❒ Lab Reports
❒ Billing Records
❒ Memo
❒ Work Status
❒ Entire medical record
❒ X-Rays (CD only)
❒ MRI (CD only)
❒ Other: _____

Information can be in: ❒ CD ❒ Paper ❒ Email ❒ USB

• **Redisclosure:** I understand that any disclosure of information carries with it the potential for redisclosure and that the information then may not be protected by federal confidentiality rules.

• **Right to Revoke:** I understand that I have the right to revoke this authorization at any time. I understand that my revocation must be in writing. And I understand that the revocation will not apply to information already released based on this authorization.

• **Copy Fees:** I agree to pay the cost of labor and material per the federal/state guidelines.

• **X-Ray CD:** No charge.

• **Other Rights:**

a) I understand that authorizing the disclosure of this health information is voluntary. I can refuse to sign this authorization. I do not need to sign this form to assure treatment. However, if this authorization is needed for participation in a research study, my enrollment in the research study may be denied.
b) I understand that I may inspect or obtain a copy of the information to be used or disclosed.

• **Sensitive Information**: The information authorized for release may include records which indicate the presence of a communicable or venereal disease including, but not limited to, hepatitis, syphilis, gonorrhea and the human immunodeficiency virus also known as Acquired Immune Deficiency Syndrome (AIDS) and/or mental health information.

_____
Patient Initials

The information authorized for release also may include records related to mental health and/or substance abuse treatment.

• **Expiration:** Unless I revoke this authorization in writing, I understand this authorization is valid sixty (60) days from the date of the signature; unless updated below.

❑ **Duration of Treatment**: _____

(up to 1 year)

_____ _____

Patient Name Date of Birth

_____ _____

Signature of patient or personal representative Date

If signed by personal representative, relationship to patient: _____

❑ Patient was offered a copy of this authorization
❑ Patient or legal representative identity verified by picture identification.

❑ Mailed ❑ Faxed ❑ Emailed Sent on: _____ ❑ Picked-up on _____

Initials: _____

OSMC complies with applicable Federal civil rights laws and does not discriminate on the basis of race, color, national origin, religion, pregnancy, sex, sexual orientation, gender identity, age, or disability.

Spanish
ATENCIÓN: si habla español, tiene a su disposición servicios gratuitos de asistencia lingüística. Llame al 1-800-398-2058.

Chinese
注意：如果您使用繁體中文，您可以免費獲得語言援助服務。請致電 1- 800-398-2058。