Authorization for Norwich Orthopedic Group, P.C., to use/Disclose My Health Information

Patient name:_____Date of Birth:_____

Other name used:_____

I. My Authorization

You may use or disclose the following health care information (check all that apply):

[ ] Medical /Clinical/ Surgical [ ] HIV/ AIDS

[ ] Psychiatric

[ ] Other [specify]: _____

[ ] Exclusions [specify]: _____

You may disclose this health information to:

Name (or title) and organization_____

Address: _____City_____State_____Zip_____

This authorization ends: [ ] on (date) _____

[ ] when the following event occurs_____

II. My Rights

I understand I do not have to sign this authorization in order to get health care benefits (treatment, payment or enrollment). However, I do have to sign an authorization form:

- To take part in a research study.

Or

- To receive health care when the purpose is to create health information for a third party.

I may revoke this authorization in writing. If I did, it would not affect any actions already taken by Norwich Orthopedic Group, PC., based upon this I may not be able to revoke this authorization if its purpose was to obtain insurance. A way to revoke this authorization is:

- Write a letter to the office.

Once the office discloses health information, the person or organization that receives it may re-disclose it. Privacy laws may no longer protect it.

_____ _____ _____

Patient or legally authorized individual signature Date Time

_____ _____

Printed Name if signed on behalf of the patient Relationship (parent, legal guardian, personal representative, etc,)

Note: The confidentiality of medical information, psychiatric information, and/or HIV/AIDS testing information is required under Connecticut State Statues. Chapter 899, Section 52-146 and 89-246. This information cannot be transmitted to anyone else without consent or through other authorizations as provided in the statues of the State of Connecticut.