

**UNIVERSITY ORTHOPAEDIC CLINIC AND SPINE CENTER**

Post Office Box 2447  
Tuscaloosa, Alabama 35403  
Phone 205/345-0192 Fax: 205/345-7341

**Policy 3.3 Request for UOC to Release Records  
AUTHORIZATION FOR RELEASE OF PROTECTED HEALTH INFORMATION PURSUANT TO HIPAA**

NAME OF PATIENT: \_\_\_\_\_ Medical Record # \_\_\_\_\_

ADDRESS: \_\_\_\_\_

DATE OF BIRTH: \_\_\_\_\_ SOCIAL SECURITY NUMBER: \_\_\_\_\_

By signing below, you hereby authorize us to use or disclose information about yourself (or another person for whom you have the authority to sign) that is protected under federal law, for the sole purpose and time period described below. You may refuse to sign this authorization. Subject to certain exceptions, you have the right to inspect and copy the protected health information.

There may be a fee for this request. Please check before making your selection.  
A separate authorization is listed below for sensitive information.

The following information is to be disclosed: (Please check to authorize release )

\_\_\_ Any and All Medical Records (ENTIRE CHART)

\_\_\_ Progress Notes from Dr. \_\_\_\_\_ and Dr \_\_\_\_\_ or \_\_\_ All UOC Physicians

\_\_\_ Dates of Service \_\_\_\_\_ to \_\_\_\_\_

\_\_\_ Specific Request: \_\_\_\_\_

\_\_\_ Itemized Statement: Patient Balance Must be Paid prior to receiving

**SENSITIVE PRIVILEGED INFORMATION: I understand that this may include information relating to (check to authorize release)**

\_\_\_ Alcohol / Drug Information

\_\_\_ Mental Health information

\_\_\_ AIDS/HIV-Related Information

\_\_\_ Sexually Transmitted Disease Information

Information that may not be used or disclosed: PLEASE SPECIFY:

The name or other specific identification of the person(s) or class of persons authorized to disclose my protected health information:

**University Orthopaedic Clinic and Spine Center**

Who is authorized to receive your protected health information:

Name \_\_\_\_\_ Phone \_\_\_\_\_

City, State \_\_\_\_\_ Fax \_\_\_\_\_

Expiration date or an expiration event. \_\_\_\_\_

It is my understanding that if I do not fill in an expiration date this authorization will expire in 90 days.

Use or disclosure of the PHI will not result in remuneration to us.

This information about you is protected under federal law, and you have the right to revoke this authorization in writing. Please be advised, however that any revocation will be effective only to the extent we have not already taken action in reliance on your authorization. By signing below, you recognize that the protected health information used or disclosed pursuant to this authorization may be subject to re-disclosure by the recipient of this disclosure and may no longer be protected under federal law. We will not condition treatment based on your authorization. You may refuse to sign the authorization.

University Orthopaedic Clinic P.C. will not condition treatment, payment, enrollment in the health plan, or eligibility of benefits on the individual's providing authorization for the requested use or disclosure.

Patient Signature or Personal Legal Representative \_\_\_\_\_ Date \_\_\_\_\_

As a personal representative, I have authority to act for the individual because I am \_\_\_\_\_