

**UNIVERSITY ORTHOPAEDIC CLINIC AND SPINE CENTER**

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

**Policy 3.3**

**Request for UOC To Release Records**

**AUTHORIZATION FOR USE AND DISCLOSURE OF PROTECTED HEALTH INFORMATION**

NAME OF PATIENT: \_\_\_\_\_ Chart # \_\_\_\_\_

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.

**Information to be used or disclosed AND purpose of the use and disclosure (must be identified in a specified and meaningful fashion).**

**Purpose of Request:** \_\_\_\_\_  
\_\_\_\_\_ All Medical Records by UOC Physicians  
\_\_\_\_\_ All Medical Records For Treatment by UOC Physicians from DOS \_\_\_\_\_ to DOS \_\_\_\_\_  
\_\_\_\_\_ Itemized Statement Note: Patient Balance Must be Paid prior to receiving.  
\_\_\_\_\_ Other, Please Specify: \_\_\_\_\_

**Information that may not be used or disclosed:**

**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 \_\_\_\_\_ City, State \_\_\_\_\_

Phone \_\_\_\_\_ 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. This authorization should expire \_\_\_\_\_

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: \_\_\_\_\_

