# Orthopedic & Sports Medicine Specialists (OSMS)
# Authorization for Release of Patient Identifiable Health Information

**Patient Name:** _____

**Patient DOB:** _____

I authorize the use or disclosure of the above named individuals health information as described below. I understand that I have the right to refuse to sign this authorization. OSMS is authorized to send and to receive the records.

OSMS is authorized to ***SEND*** the records to individual listed below.

**Name, Address, Fax & Phone number for individual or organization authorized to *RECEIVE* the records:**

_____

## If OSMS is to receive the records:

2223 Lime Kiln Rd Ste 1 Phone: 920.430.8113
Green Bay, WI 54311 Fax: 920.430.8122

**Information that may be released** (check all that apply)**:**

☐ Office Notes ☐ Operative Reports ☐Therapy/Test Results ☐ Radiology CD/Report
☐ Any Disability/FMLA Information
☐ Information relating to mental health, alcohol or drug abuse or developmental disability
☐HIV test results (according to Wis. Stat. 252.15 I have the right to request a list of releases made of my HIV test results without my consent),

This authorization is to remain in effect for one year or unless otherwise noted _____

Specific date range you would like released: _____

_____ _____
Signature of Patient or Personal Representative, person authorized relationship, legal authority by patient or other legal authority

Date

**Right to inspect or copy the information to be used or disclosed:** I understand that I have the right to inspect or copy the information used or disclosed in the authorization. I can contact OSMS Privacy Officer.

**Right to receive a copy of this authorization:** I understand that if I agree to sign this authorization, which I am not required to do, I will receive a copy of this signed authorization.

**Redisclosure of information by recipient:** I understand that any disclosure of information carries with it the potential for an unauthorized redisclosure and the information may not be protected by confidentiality rules. If I have questions about the disclosure of my health information, I can contact OSMS Privacy Officer at 2223 Lime Kiln Rd Green Bay WI 54311 or 920.430.8113.

**Prohibition of Conditions:** OSMS may not condition treatment, payment, enrollment in a health plan, or eligibility for benefits based on the provision that I authorize this disclosure of my protected health information.

**Right to Revoke Authorization:** I understand that I have the right to revoke this authorization at any time. I understand that if I revoke this authorization I must provide the revocation in writing to OSMS. I understand that the revocation will not apply to information that has already been released in response to this authorization. I understand that the revocation will not apply to my insurance company when the law provides my insurer with the right to contest a claim under my policy.

I understand that if OSMS uses this authorization for marketing activities, I will be informed if they receive any direct or indirect remuneration related to the use or disclosure of my protected health information.