Suncoast Orthopaedic Surgery & Sports Medicine, P.A.
836 Sunset Lake Blvd Ste A-205
Venice, FL 34292-7556
941-485-1505
HIPAA AUTHORIZATION FORM

| ___________________________ | ___________________________ |
|---|---|
| Patient's Full Name | Patient's Social Security/Medical Record Number |
| ___________________________ | ___________________________ |
| Address | Patient's Date of Birth |
| ___________________________ | ___________________________ |
| City, State Zip Code | Patient's Telephone Number |

I hereby authorize use or disclosure of protected health information about me as described below.

1. The following specific person/class of person/facility is authorized to use or disclose information about me:___________________________
2. The following person (or class of persons) may receive disclosure of protected health information about me:___________________________
   His/her/its Name
   ___________________________
   Address
   ___________________________
   City, State Zip Code
3. The specific information that should be disclosed is (please give dates of service, if possible):
   ___________________________
   ___________________________
   ___________________________

**UNLESS YOU SIGN HERE,** NO INFORMATION ABOUT ALCOHOL/SUBSTANCE ABUSE, HIV/AIDS, OR MENTAL HEALTH WILL BE DISCLOSED:

**YES,** DISCLOSE THIS INFORMATION* ___________________________

**NO, DO NOT** DISCLOSE THIS INFORMATION*___________________________

4. I understand that the information used or disclosed may be subject to re-disclosure by the person or class of Persons or facility receiving it, and would then no longer be protected by federal privacy regulations.
5. I may revoke this authorization by notifying ___________________ in writing of my desire to revoke it. However, I understand that any action taken in reliance on this authorization cannot be reversed, and my revocation will not affect those actions.
6. My purpose/use of the information is for ___________________________.
7. This authorization expires on _______________20__, OR upon occurrence of the following event that relates to me or to the purpose of the intended use or disclosure information about me ___________________.

**FEES FOR COPIES: Federal and state laws permit a fee to be charged for the copying of patient records. This facility is contracted with HealthPort to make copies. You may be required to pre-pay for the copies; if not, then your copies will be mailed along with an invoice.**

**THIS FORM MUST BE FULLY COMPLETED BEFORE SIGNING – note that signature is required in two places.***

| ___________________________ | ___________________ | ___________________ |
|---|---|---|
| Signature of Individual*<br>(The person about whom the information relates)<br>OR, if applicable – | Date of individual's signature | Date of Birth or Social Security Number |
| ___________________________ | ___________________ | ___________________ |
| Signature of Guardian* or Personal Representative of Patient's Estate | Date of Guardian's/Personal Representative's signature | Description of Authority to Act for the individual |

A copy of this completed, signed and dated form must be given to the Individual or other signator

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Office Use Only

| ___________________ | ___________________ | ___________________ |
|---|---|---|
| Received | Processed by | Log # |