



**ADVANCED ORTHOPEDICS
& SPORTS MEDICINE**

**SEPEHR BADY, MD
THOMMAN KURUVILLA, DPM
X. NICK LIU, DO
TIMOTHY J. TRAINOR, MD
RANDALL E. YEE, DO**

**AUTHORIZATION TO DISCLOSE PROTECTED HEALTH INFORMATION
TO FAMILY AND/OR CAREGIVERS**

PATIENT NAME: _____

NAME OF PARENT/GUARDIAN (IF PATIENT IS MINOR) _____

In the event Advanced Orthopedics & Sports Medicine may need to give your test results or medical information, may we.....(Check all that apply):

_____ Leave detailed message on an answering machine. _____ Leave a message with my spouse or family member

_____ Call you on your cellular phone, the phone number is: _____

_____ Call you at work, the phone number is: _____

I, _____ whose date of birth is: _____, give

Advanced Orthopedics and Sports Medicine, Dr. Kuruvilla, Dr. Bady, Dr. Liu, Dr. Trainor and/or Dr. Yee and staff the Authorization to disclose my protected health information to the following family, friends, and/or caregiver:

Include the name of your short/long term disability provider to avoid delays in processing your claim.

Name: _____ Relationship to patient: _____

Name: _____ Relationship to patient: _____

Name: _____ Relationship to patient: _____

Name: _____ Relationship to patient: _____

I understand that I have the right to revoke this authorization at any time. I understand that if I revoke this authorization I must do so in writing and present my written revocation to the Medical Records Department of Advanced Orthopedics and Sports Medicine, Dr. Kuruvilla, Dr. Liu, Dr. Trainor and/or Dr. Yee.

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 information shared in the process of treatment, payment, or healthcare operations.

I understand that authorizing the disclosure of this health information is voluntary. I can refuse to sign this authorization and I need not sign this form in order to assure treatment. I understand that any disclosure of information carries with it the potential for an unauthorized re-disclosure and the information may not be protected by Federal Confidentiality Rules. If I have questions about the disclosure of my health information, I can receive further information from my doctor or his staff.

Unless otherwise revoked this authorization will expire on the following date, event, or condition: _____
If I fail to specify a date, this authorization will expire one (1) year from the signature on this form.

_____/_____
SIGNATURE OF PATIENT DATE

_____/_____
SIGNATURE OF PARENT/GUARDIAN (IF PATIENT IS A MINOR) DATE

_____/_____/_____
NAME OF WITNESS SIGNATURE OF WITNESS DATE