NOTICE OF PRIVACY PRACTICES AND AUTHORIZATION FOR RELEASE OF PROTECTED HEALTH INFORMATION

I HAVE REVIEWED A COPY OF THE "NOTICE OF PRIVACY PRACTICES" FROM THE ORTHOPAEDIC CENTER OF CORPUS CHRISTI, WHICH EXPLAINS HOW MY MEDICAL INFORMATION WILL BE USED AND DISCLOSED. I UNDERSTAND THAT I AM ENTITLED TO RECEIVE A COPY OF THIS DOCUMENT.

SIGNATURE_____DATE_____

RELEASE OF HEALTH INFORMATION

IF YOU WISH TO HAVE YOUR SPOUSE, FAMILY MEMBER, COACH/TRAINER OR OTHER TO HAVE ACCESS TO YOUR PROTECTED HEALTH INFORMATION, PLEASE PROVIDE US WITH THE NAME(S) OF THE PERSON(S) OR ENTITY.

1. NAME: _____RELATIONSHIP: _____

PLACE AN (X) NEXT TO THE INFORMATION YOU ARE AUTHORIZING TO BE RELEASED TO THE ABOVE NAMED PERSON.

_____ANY AND ALL INFORMATION

_____LAB TEST RESULTS

_____MEDICAL RECORDS

_____FINANCIAL HISTORY

_____APPOINTMENT DATE AND TIME

SIGNATURE OF PATIENT_____

BY SIGNING THIS FORM, I AUTHORIZE THE ORTHOPAEDIC CENTER OF CORPUS CHRISTI TO USE AND DISCLOSE THE PROTECTED HEALTH INFORMATION AS DESCRIBED ABOVE. THIS AUTHORIZATION SHALL BE IN FORCE AND EFFECTIVE, UNTIL I REVOKE THIS AUTHORIZATION IN WRITING TO THE COMPLIANCE OFFICER LISTED BELOW.

LINDA HERNANDEZ
COMPLIANCE OFFICER
6118 PARKWAY DRIVE
CORPUS CHRISTI, TEXAS 78414