**Office of Sports Medicine**
*A Division of Health & Wellness Services*
**Keystone Hall**
**Kutztown , PA 19530**
**Telephone: 610-683-4085**
**Fax: 610-683-4664**

**AUTHORIZATION FOR USE/DISCLOSURE OF PROTECTED HEALTH INFORMATION (PHI)**
***PLEASE PRINT***

Name _____ Last _____ First _____ Social Security # _____ Date of Birth _____

Address _____ Phone (_____) _____

City/State/Zip _____

* * * * * * * * * * * * * * * * * * * * * * * * * * * * * * * * * * * * * * * * * * * * * * * * * * * * * * * * * * * * * * * *

I authorize the Office of Sports Medicine to DISCLOSE Protected Health Information contained in my medical record TO:

Name/Organization _____

Address _____ Phone (_____) _____

City/State/Zip _____

*Fax (_____) _____ (Emergency Situation only)

* * * * * * * * * * * * * * * * * * * * * * * * * * * * * * * * * * * * * * * * * * * * * * * * * * * * * * * * * * * * * * * *

REASON THAT I AM AUTHORIZING DISCLOSURE:

☐ Continuation of Care ☐ Payment of a Claim ☐ Personal Use

☐ Other _____

EXTENT OF INFORMATION TO BE SENT:

☐ All Dates of Treatment ☐ Date(s) or Date Range _____

☐ For the following Condition/Injury(s) _____

_____

TYPE OF INFORMATION TO BE DISCLOSED:

☐ Office Visit /Surgery Notes ☐ Treatment Notes ☐ Laboratory Reports
☐ Radiology/ Test Reports ☐ Athletic Training/ Physical Therapy Notes

☐ Other _____

_____

* * * * * * * * * * * * * * * * * * * * * * * * * * * * * * * * * * * * * * * * * * * * * * * * * * * * * * * * * * * * * * * *

I understand that I have a 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 Office of Sports Medicine. 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 where the law provides my insurer with the right to contest a claim under my policy.

This authorization will expire _____: If I fail to specify an expiration date or event, this authorization will expire 90 days from the date it was signed. I understand authorizing the use or disclosure of the information identified above is voluntary. I need not sign this form to ensure health care treatment. I also understand that the information disclosed according to this release may be re-disclosed by the recipient and is no longer protected by HIPAA (Federal Regulations).

_____ _____
Signature of patient or legal representative Date

If signed by legal representative, relationship to patient _____

* * * * * * * * * * * * * * * * * * * * * * * * * * * * * * * * * * * * * * * * * * * * * * * * * * * * * * * * * * * * * * * *

Official Use Only: Date/Person Assisting Patient with Form Completion: _____