Office of Sports Medicine
Eugene Fellin, DO, Team Physician
Keystone Hall 124
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 following Institution/ Provider to DISCLOSE Protected Health Information contained in my medical record **to KU:**

Institution/Provider____

Address ______________________ Phone (______)____________________

City/State/Zip ______________________ *Fax (_______)____________________

_____ **Please mail to: Kutztown University, Sports Medicine, Keystone Hall 124, Kutztown, PA 19530**

_____ **Please fax to Kutztown University, Sports Medicine at 610-683-4664**

* *

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)____

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TYPE OF INFORMATION TO BE DISCLOSED:

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

☐ Other____

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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 Provider listed above. 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____

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