Boston Sports Medicine

AUTHORIZATION TO USE AND DISCLOSE PATIENT INFORMATION

As a patient of Boston Sports Medicine, Inc. you have the right to know how we may use and disclose information about you. Information about our disclosure is provided in our Notice of Patient Privacy Practices and a copy of this notice has been provided to you. You have the right to review our notice before signing this form and should read our notice carefully before signing this form. As our notice of Privacy Practices explains that we need your authorization to use or disclose information about you for any purpose other than treatment, payment, or normal healthcare operations.

1. I authorize the use and disclosure of my protected health information for the following purpose (s):

_____

2. By initialing and signing below, I authorize the use and disclosure of the following types of protected health information that may pertain to any health care I have received to date. I realize that **I will be assessed a fee of $35.00** to produce the copy of my protected health information. (Please initial the category of information you wish to authorize use and disclosure)

_____My entire record

_____The following specific information_____

3. I authorize my protected health information to be disclosed to:_____

_____

_____

4. I HAVE BEEN TOLD THAT INFORMATION OTHERWISE PROTECTED BY LAW AND DISCLOSED UNDER THIS AUTHORIZATION MAY BE SUBJECT TO REDISCLOSURE AND MAY NO LONGER BE PROTECTED BY LAW, INCLUDING, BUT NOT LIMITED TO PRIVACY REGULATIONS ISSUED BY THE UNITED STATES DEPARTMENT OF HEALTH AND HUMAN SERVICES.

5. I agree that this authorization for use and disclosure of my identifiable health information will be effective from the date I sign this document until this authorization expires or until I revoke this authorization. I understand that I may revoke this authorization at any time by giving Boston Sports Medicine, Inc. notice in writing at P.O. Box 322, Allston, MA. I also understand that treatment, payment, enrollment in a health plan, or eligibility for certain health benefits cannot be conditioned on my providing this authorization. Revocation of my authorization for use and disclosure of information related to drug and alcohol abuse treatment may be provided orally. This authorization will expire on_____(requires a date or an event)

By signing below I agree that my protected health information may be used or disclosed as described above:

Printed Name of Patient:_____

_____

Signature of Patient or Legally Authorized Representative Date

Authority of Legally Authorized Representative:_____

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