Concord Orthopaedics Professional Association (COPA)
Authorization To Use Or Disclose My Protected Health Information (PHI)

Patient Name: _____ **DOB:** _____ **Phone #** _____

I authorize COPA to ☐ ***USE (REQUEST)*** or ☐ **DISCLOSE (RELEASE)** the following Protected Health Information, by any acceptable means, including fax or e-mail:

	Physician(s):	Date (s) of Service or Relating to the Following Condition:
☐ **Office Notes**	_____	_____
☐ **Operative Report**	_____	_____
☐ **Diagnostics**	_____	_____
☐ **X-Rays (films)**	_____	_____
☐ **Other**	_____	_____

FOR THE PURPOSE OF (Use/Request):

☐ ***Continuity of Care-Requested of (need full name of physician or health care facility & complete address)***

_____

_____

FOR THE PURPOSE OF (Disclose/Release):

☐ **Patient Request (personal use) ($0.50 per page)**

☐ **M.D. Appointment with** _____ **on** _____

☐ **Other** _____

INSTRUCTIONS:

☐ ***Mail to Concord Orthopaedics, 264 Pleasant Street, Concord, NH 03301 Attn:_____***
or Fax to (603) 717-7364.

☐ **Patient will pick up on** _____

☐ **Mail to patient @** _____

☐ **Mail to physician @** _____

☐ **Other** _____

- I understand that the information in my health records may include information relating to sexually transmitted disease, acquired immunodeficiency syndrome (AIDS), or human immunodeficiency virus (HIV). It may also include information about behavioral or mental health services, and treatment for alcohol or drug abuse.
- I understand that this authorization shall expire one year from its effective date, unless it is revoked prior to the expiration date.
- I understand that I have the right to revoke this Authorization by providing written notice to the attention of the HIPAA Privacy Officer at COPA. The revocation will be effective upon receipt except with respect to uses or disclosures made prior to receipt and in reliance upon this Authorization.
- I understand that once the requested information is disclosed pursuant to this Authorization, Concord Orthopaedics will no longer have control over the information and there is a potential that it may be re-disclosed by the recipient and may not be protected by the Privacy Rules under the Health Insurance Portability and Accountability Act.
- I understand that COPA can not require that I sign this Authorization as a condition to the provision of services.
- I am entitled to a copy of this signed Authorization Form upon request.

_____ _____
Witness Signature Signature of Patient or Legal Representative

_____ _____
Print Name of Witness Print name of Patient or Legal Representative & Relationship to Patient

_____
Date

****

Internal use only: Processed by: _____ Date: _____