PATIENT AUTHORIZATION

TREATMENT CONDITIONED ON DISCLOSURE TO THIRD PARTY

Name of Patient ________________________________ **Medical Record #** ________________

Date of Birth ___________________________________ **Phone #** _________________________

Patient Address ____

____

Last four of Social Security# XXX-XX- ____

Approximate Dates of Treatment ____

1. I authorize the following health care provider or facility **TO DISCLOSE** my patient information:

___Outpatient Clinic(s):____

___Specific Provider(s): ____

___Other: Name: ______________________Phone:___________________Fax:___________________

Address: ____

2. I authorize the following person or organization **TO RECEIVE** my patient information:

Kenneth G. Berliner, M.D.

4710 Katy Freeway

Houston, TX 77007

Ph# 713-936-5735 Main Fax# 832-538-0366 or Fax# 832-203-7121

3. Please disclose the following information: (circle to indicate your selection)

History and Physical	Psychological Evaluation	Discharge Summary
Educational Reports	Treatment Plans	Psychosocial History
Radiology and Lab Reports	Consultation Reports	Immunizations
Outpatient Clinical Records		

Other: ____

4. The purpose of this disclosure of your patient records is: ___________________________________

5. I understand that if the authorized recipient of this information is not a health care provider or health plan covered by federal privacy regulations, the information he/she receives will no longer be protected by these regulations, and the recipient may re-disclose the information. However, the recipient may be prohibited from disclosing substance abuse information under the Federal Substance Abuse Confidentiality Requirements.

6. I understand that if I do not sign this authorization, Lone Star Orthopedics will not perform the _________________________________ I am requesting. I may inspect or copy any information used or disclosed under this authorization.
7. I understand that I may revoke this authorization in writing at any time by sending a written revocation of authorization to:

Lonestar Orthopedics
4710 Katy Freeway
Houston, Texas 77007

I understand that my revocation is not effective to the extent that action has been taken in reliance on this authorization. This authorization expires (check one):

______ 1 year from the date I sign below ______ one time disclosure only

Patient's Name Patients Signature Date

Name of Personal Representative (if applicable)

If signing as Personal Representative, describe authority to act for patient and submit documentation showing such authority:____

Name of Witness Signature of Lone Star Orthopedics Workforce Member Date

(No notary is required if the patient appears personally to the Lone Star Orthopedics facility and presents identification.)

SUBSCRIBED AND SWORN before me this ____ day of ________________, 20____.

NOTARY PUBLIC
Residing in ________________________________
My Commission expires: _____________________

Authorization documented in HIPAA Management Application.
Lone Star Orthopedics Staff: After processing, place this form into the patient's medical record.