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Southeast Kansas Orthopedic Clinic

HIPAA Privacy Authorization Form

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Authorization for use or Disclosure of Protected Health Information

1. I hereby authorize SEK Ortho to use and/or disclose my protected health information ("PHI") described below.

2. I hereby authorize the release of my PHI which may include the following examples:
   - Appointment dates and times
   - Tests that have been received
   - Test results
   - Other health information

3. In addition to the authorization for release of my PHI described in section 2 of this authorization, I authorize disclosure of information regarding my billing, condition, treatment, and prognosis to the following individual(s):

Name: asadf _____ ***Relationship:*** _____
_____ ***Telephone:*** _____

Name: _____ ***Relationship:*** _____
_____ ***Telephone:*** _____

Name: _____ ***Relationship:*** _____
_____ ***Telephone:*** _____

4. This medical information may be used by the persons I authorize to receive this information for medical treatment or consultation, billing, or claims payment, or other purposes as I may direct.
5. I understand that I have the right to revoke this authorization, in writing, at any time. I understand that a revocation is not effective to the extent that any person or entity has already acted in reliance on my authorization.
6. I understand that information used or disclosed pursuant to this authorization may be disclosed by the recipient and may no longer be protected by federal or state law.

_____ _____
Signature of Patient *Date*

_____ _____
Print Patient Name *Date of Birth*