NERVE, BONE & JOINT INSTITUTE

3 Washington Circle NW
Suite 207/208
Washington, DC 20037

Main: (202) 955-6001
Fax: (202) 955-6008

HIPAA AUTHORIZATION FORM

This is an authorization for use or disclosure of Protected Health Information (Required by the Health Insurance Portability and Accountability Act, 45 C.F.R. Parts 160 & 164).

Patient Full Name _____
(Please Print) Last Name, First Name, Middle Initial

Patient Date of Birth_____
Month/Day/Year

Patient Phone #_____ **Patient Email** _____

Address _____
Street

_____
City State Zip Code

I authorize Nerve, Bone, and Joint Institute to use and disclose the protected health information described below to _____ (individual seeking the information). This authorization for release of information covers the period of healthcare from: _____ to _____.

I authorize the release of my complete health record with the exception of the following information:

(☑) Mental health records
(☑) Communicable diseases (including HIV and AIDS)
(☑) Alcohol/drug abuse treatment
(☑) Other (please specify): _____

- This medical information may be used by the person I authorize to receive this information for medical treatment or consultation, billing or claims payment, or other purposes as I may direct.
- This authorization shall be in force and effect until _____ (date or event), at which time this authorization expires.

NERVE, BONE & JOINT INSTITUTE

- 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 or if my authorization was obtained as a condition of obtaining insurance coverage and the insurer has a legal right to contest a claim.
- I understand that my treatment, payment, enrollment, or eligibility for benefits will not be conditioned on whether I sign this authorization.
- 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.
- I understand that I am responsible for paying for any applicable materials, copying and/or mailing charges for the above requested medical records.

Please indicate how you would like to obtain this medical information.

(☑) I will pick up

(☑) Please mail to: _____

_____

(☑) Please fax to: _____

Signature of Patient:	**Date:**

After completion of this form, please fax, mail or hand-deliver a copy of the completed and singed document to our office.