AUTHORIZATION FOR THE USE AND DISCLOSURE OF PROTECTED HEALTH INFORMATION

I hereby authorize ____ to use and disclose protected health information from the record of:

Patient Name: __________________________________ **Telephone Number**: ______________________________

Social Security Number: _________________________ **Date of Birth**: ___________________________________

Covering the periods(s) of hospitalization from:

Date(s) of Admission/Discharge: ____

Information will be released to:

Orthopaedic Surgery & Sports Medicine of San Antonio
Office of Andrew L. Whaley, M.D. and Joseph Taylor, F.N.P.
143 West Sunset, Suite 100
San Antonio, TX 78209
P# 210.293.2663
Fax# 210.293.2719

I hereby authorize the following information to be disclosed:

__ Complete Health Record(s) __ Operative Report __ Psychosocial Evaluation
__ Discharge Summary __ X-ray, Lab, Pathology __ History & Physical
__ Psychiatric Evaluation __ Progress/Psychotherapy Notes
__ Other: ____

Purpose of Disclosure: Continuum of care and insurance purposes

I hereby also consent to the release of the following information, which may have specific statutory protection: Information about substance abuse and treatment, mental health information, AIDS/HIV test results, diagnosis, treatment or drug test results and healthcare information received from another healthcare institution.

I understand that to the extent any Recipient of this information, as identified above, is not a "covered entity" under Federal or Texas privacy law, the information may no longer be protected by Federal and Texas privacy law once it is disclosed to the Recipient and, therefore, may be subject to re-disclosure by the Recipient.

I understand that the **Orthopaedic Surgery and Sports Medicine of San Antonio Offices of Andrew L. Whaley, M.D. and Joseph Taylor, F.N.P.** may not condition treatment on my completion of this authorization form.

I understand that I may revoke this authorization in writing at any time except to the extent that **Orthopaedic Surgery and Sports Medicine of San Antonio Offices of Andrew L. Whaley, M.D. and Joseph Taylor, F.N.P.** has already relied on this information. I understand that to revoke this authorization, I must do so in writing and present it to the Medical Record Department. Unless otherwise specified, this authorization shall expire 180 days from the date of signature.

_______________________________________ _______________________
Patient Signature Date

_______________________________________ _______________________
Parent/Guardian/Legal Representation Signature Date