Orthopaedic Specialty Group, P.C. & Fairfield Surgery Center, LLC
75 Kings Highway Cutoff, Fairfield, CT 06824

Authorization For Use or Disclosure of Protected Health Information

As required by the Health Insurance Portability and Accountability Act of 1996 (HIPAA) and Connecticut law, this practice may not use or disclose your individually identifiable health information without your authorization except as provided in our Notice of Privacy Practices. Your completion of this form means that you are giving permission for the uses and disclosure described below. Please review and complete this form carefully. It may be invalid if not fully completed. You may wish to ask the person or entity you want to receive your information to complete the sections detailing the information to be released and the purposes for the disclosure.

I hereby authorize this medical practice to use and disclose health information concerning:

Patient name: ________________________________ Date of birth: ______________
(please print)

Person or organization authorized to provide the health information:

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Person or organization authorized to receive the health information:

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Description of health information to be used or disclosed (including dates):

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Purpose of the disclosure (if you do not want to explain the purpose, write "At the request of the individual"):

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I have read and understand the following statements about my rights:

- I am not required to sign this form in order to receive my health care.
- I may revoke this authorization at any time prior to its expiration date by notifying the medical practice in writing. This revocation will not have any effect on any actions taken before the medical practice received the revocation.
- I may receive a copy of this authorization form.
- Once this information is disclosed pursuant to this Authorization, it is no longer protected by this medical practice's privacy policies, and may possibly be re-disclosed by the recipient.

This authorization is effective now and will remain in effect until:

Date: ________________ End of event: ____

(please describe event)

Signed: _______________________________ Dated: ___________________________

Print Name: ___________________________

If not signed by the patient, please indicate relationship: ________________________

Note: If this is an authorization for the use or disclosure of psychotherapy notes, it may not be combined with an authorization for the use and disclosure of any other type of health information except other psychotherapy notes.