



**Amarillo Bone & Joint Clinic, L.L.P.**  
**3501 Soncy Rd., Suite 129**  
**Amarillo, TX 79119**  
**(806) 468-9700 Fax (806) 468-9771**

**Authorization for the Disclosure of Health Information**

Patient Name \_\_\_\_\_ Date of Birth \_\_\_\_\_  
 Social Security # \_\_\_\_\_ Telephone Number \_\_\_\_\_  
 Address \_\_\_\_\_  
 City, State, Zip \_\_\_\_\_

I hereby authorize and request Amarillo Bone & Joint Clinic, LLP to  provide to or  receive from:

Name/Facility \_\_\_\_\_  
 Address \_\_\_\_\_  
 City, State, Zip \_\_\_\_\_  
 Telephone Number ( ) \_\_\_\_\_ Fax Number ( ) \_\_\_\_\_

The type and amount of information to be used or disclosed is as follows:

Specify date(s) of Encounter(s)/Hospitalization(s) \_\_\_\_\_

- |   |   |  |
|---|---|--|
| <input type="checkbox"/> Complete Medical Record                          | <input type="checkbox"/> History & Physical | <input type="checkbox"/> Operative Report  |
| <input type="checkbox"/> Physician's Office Progress Notes                | <input type="checkbox"/> Lab Reports        | <input type="checkbox"/> Problem List      |
| <input type="checkbox"/> X-Ray Reports                                    | <input type="checkbox"/> X-Ray Film(s)      | <input type="checkbox"/> Discharge Summary |
| <input type="checkbox"/> Photographs, Videotapes, digital or other images | <input type="checkbox"/> Other _____        |  |

with regard to \_\_\_\_\_ medical/hospital records for the purpose of:

**(Patient Name)**

- Continuity of Care  Billing and Payment of Bill  Other (explain) \_\_\_\_\_

I understand that this authorization can be revoked, in writing, at any time except to the extent that disclosure made in good faith has already occurred in reliance upon this authorization. This authorization shall expire one year after the date appearing below except for payment of all claims at which time this authorization may be in force greater than one year.

This authorization is for full disclosure of all health data which may included any information related to care for my impairment(s) information about how my impairment(s) affects my ability to complete tasks and activities of daily living, information about how my impairment(s) affect my ability to work; and/or related to drug, alcohol, mental health, psychiatric conditions, and/or sexually transmitted disease, Sickle Cell anemia, including AIDS/HIV information [42 CFR part 2]. Such records will be disclosed unless you specify information that you wish to be excluded.

I understand that authorizing the disclosure of this health information is voluntary. I can refuse to sign this authorization. I need not sign this form in order to ensure treatment. I understand that I may inspect or copy the information to be used or disclosed, as provided in 45 CFR 164.524. If I have questions about disclosure of my health information, I can contact Amarillo Bone & Joint Clinic, LLP.

Facsimile transmission of this form will be deemed as having the same force and effect as an original. The risks associated with the use of facsimile transmission are understood.

This form ( ) was read BY me ( ) was read TO me. I have been offered the opportunity to ask questions about this form, and I fully understand its contents and meaning. All blanks were filled in before the form was signed by me.

\_\_\_\_\_  
 Patient or Authorized Representative Signature \_\_\_\_\_  
Date

If signed by Legal Representative, Relationship to Patient \_\_\_\_\_

\_\_\_\_\_  
 Witness Signature \_\_\_\_\_  
Date

Interpreter's Statement (if interpreter assisted): I have translated the information presented orally to the patient by: (Employee's Name) _____	
I have also read the Authorization for Disclosure of Health Information Form to: (Patient Name) _____ in (language) _____	
_____ Signature of Interpreter	_____ Date