



AUTHORIZATION TO USE OR DISCLOSE PROTECTED HEALTH INFORMATION

I hereby authorize _____ (covered entity) to use or disclose the following Protected Health Information (PHI) from the medical records of the patient listed below to:

Requesting Practice: Bienville Orthopaedic Specialists, LLC
Requesting Physician: _____
 1720-A Medical Park Drive, Suite 220
Requestor Address: Biloxi, MS 39532
Requestor Phone Number: (228) 392-9355
Requestor Fax Number: (228) 392-1781
To the Attention of: _____
Patient Name: _____
Date of Birth: _____
Address: _____

Disclose the following PHI for treatment provided: From: _____ To: _____

- | | | | |
|---|---|--|--|
| <input type="checkbox"/> History and Physical | <input type="checkbox"/> Pertinent | <input type="checkbox"/> Discharge Summary | <input type="checkbox"/> Consult Notes |
| <input type="checkbox"/> Operative Report | <input type="checkbox"/> Progress Notes | <input type="checkbox"/> Physician Orders | <input type="checkbox"/> Nurse Notes |
| <input type="checkbox"/> ER Report | <input type="checkbox"/> Labs | <input type="checkbox"/> Radiology Reports | <input type="checkbox"/> Entire Chart |

The above information is disclosed for the following purposes:

- | | | | |
|---------------------------------------|--------------------------------|------------------------------------|-----------------------------------|
| <input type="checkbox"/> Medical Care | <input type="checkbox"/> Legal | <input type="checkbox"/> Insurance | <input type="checkbox"/> Personal |
|---------------------------------------|--------------------------------|------------------------------------|-----------------------------------|

I acknowledge and hereby consent to such, that the released information may contain _____ alcohol, drug abuse, psychiatric, HIV, or genetic information.

This authorization shall expire upon this date: _____

**If I fail to specify an expiration date, this authorization will expire six (6) months from the date on which it was signed.*

I understand that I have the right to revoke this authorization at any time. This may be done by presenting a written revocation to any of the Bienville Orthopaedic Specialist, LLC locations. I understand that this revocation will not apply to any information that has already been released to this authorization.

The information used or disclosed pursuant to the authorization may be subject to re-disclosure, by the recipient, and no longer protected.

I have read the above and authorize the disclosure of the protected health information as stated.

Signature of Patient/Legal Representative _____
Date
**If signed by legal representative, relationship to patient:* _____

Signature of Witness _____
Date

Mail to Requestor

Patient to pick-up

Fax to Requestor