



**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:** \_\_\_\_\_  
**Requestor Address:** 7001 Hwy 614  
 Hurley, MS 39555  
**Requestor Phone Number:** (228) 230-2663  
**Requestor Fax Number:** (228) 769-7015  
**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**