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: 15476-B Dedeaux Road
Gulfport, MS 39503
Requestor Phone Number: (228) 679-3001
Requestor Fax Number: (228) 679-3039
To the Attention of: ______________________________

Patient Name: ______________________________
Date of Birth: ______________________________
Address: ______________________________

Disclose the following PHI for treatment provided: From: _____________ **To:** _____________

- ☐ History and Physical
- ☐ Pertinent
- ☐ Discharge Summary
- ☐ Consult Notes
- ☐ Operative Report
- ☐ Progress Notes
- ☐ Physician Orders
- ☐ Nurse Notes
- ☐ ER Report
- ☐ Labs
- ☐ Radiology Reports
- ☐ Entire Chart

The above information is disclosed for the following purposes:

- ☐ Medical Care
- ☐ Legal
- ☐ Insurance
- ☐ 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**