BIENVILLE
Orthopaedic Specialists

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: 3635 Bienville Boulevard
Ocean Springs, MS 39564
Requestor Phone Number: (228) 875-1849
Requestor Fax Number: (228) 875-6257
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**