Oakland Orthopedic Partners, P.C., *offices of*
Bruce T. Henderson • Paul C. Lewis
44555 Woodward Ave., Ste 406 & 407 • Pontiac, MI 48341
Office 248.334.0524 • Fax 248.858.3887
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Limited Patient Authorization for Disclosure of Protected Health Information

Please print clearly and complete all items. Form must be signed and dated each year.

Patient Last Name ____

Patient First Name ____ Middle Initial _____

Patient Date of Birth __________________ Age ______ Patient SS # _______ - _______ - _______

I authorize Oakland Orthopedic Partners, P.C. to disclose or provide protected health information about me, as states in this authorization.

Who will be authorized to receive information (family, friends, others):

Name ____ Relationship: ________________________

Name ____ Relationship: ________________________

Name ____ Relationship: ________________________

Description of information to be disclosed - I authorize the practice to disclose the following protected health information about me to the entity, person, or persons identified above.

Entire patient record, including but not limited to (check items to disclose)

- ☐ office notes
- ☐ x-rays, hospital, nursing home, home health, hospice, & other physician records
- ☐ record of HIV and communicable disease testing
- ☐ record of mental health or substance abuse treatment
- ☐ financial history report (previous 3 years only)

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(continued)

Purpose of disclosure (please check the purpose of the disclosure or check patient request):

☐ Patient request

☐ Patient transferring to our care

☐ Patient referred to us for treatment of ______________________________

☐ Other (please specify) ______________________________

Expirations or termination of authorization: This authorization will expire at the end of the calendar year of your signature below, unless you specify an earlier termination. You must submit a new authorization after the expiration date to continue the authorization. You must have the right to terminate this authorization at any time. You must notify our privacy manager, in writing, if you decide to terminate the authorization prior to the normal expiration date.

(Please list an earlier expiration if less than one year) ______________________________

Right to revoke or terminate: As stated in our Notice of Privacy Practices, you have the right to revoke or terminate this authorization by submitting a written request to our Privacy Manager.

Non-conditioning statement: The practice places no condition to sign this authorization on the delivery of healthcare or treatment.

Redisclosure: We have no control over the person(s) you have listed to receive your protected health information. Therefore, your protected health information disclosed under this authorization will no longer be protected by the requirements of the Privacy Rule and will no longer be the responsibility of the practice.

Acknowledgement of Receipt of Notice of Privacy Practices

By signing below, I acknowledge that I have received a copy of this office's Notice of Privacy Practices Form. I have the right to receive a copy of signed authorization upon request.

Patient Signature ______________________________ Date ______________

(The section below is for office use only)

Documentation of Failure to Obtain Signed Acknowledgement

Oakland Orthopedic Partners, P.C. presented this Acknowledgement of Receipt of Notice of Privacy Practices to patient (named below). The patient refused a signature when requested (date below).

Patient Name ______________________________

Administrative Signature ______________________________ Date ______________