## Patient Authorization for The Orthopedic Center to Release Protected Health Information to Third Parties (Family Members)

By signing this authorization, I understand The Orthopedic Center Physicians' Office to use and/or disclose certain protected health information (PHI) about me to the family member(s) or personal representative listed below.

| Person to Receive the Information | Relationship to Patient |
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I authorize The Orthopedic Center Physicians' to disclose the following individually identifiable health information:

☐ Appointment information ☐ Medication information ☐ treatment information
☐ Billing information ☐ Demographic information ☐ Entire Medical Record

This authorization will expire on: ______________________________________________
(Specific expiration date or timeframe for expiration, not to exceed more than 1 year)

When my information is used or disclosed pursuant to this authorization, it may be subject to re-disclosure by the recipient and may no longer be protected by the Federal HIPAA Privacy Rule. I have the right to revoke this authorization in writing except to the extent that The Orthopedic Center Physicians' office has acted in reliance upon this authorization. My written revocation must be submitted to The Orthopedic Center's Privacy Officer at 510 Idlewild Avenue, Suite 200, Easton, MD 21601

Patient/Guarantor Signature: ______________________________ Relationship to Patient: ______________

Patient's Name:_____________________________________________ Date:____________________