Lewiston Orthopaedics

320 Warner Drive | Lewiston, ID 83501
(208) 743-3523 | (800) 841-3523 | Fax (208) 746-8741
www.lewistonortho.com
www.catalystmedicalgroup.com

Authorization for Use of Disclosure of Protected Health Information

[Note: This is a general authorization pursuant to 45 CFR § 164.508. It is not required for uses or disclosures of protected health information for treatment, payment, or health care operations (except psychotherapy notes) and certain other uses or disclosures allowed by law. An authorization for the disclosure of psychotherapy notes may not be combined with another authorization. The disclosure of information relating to drug or alcohol treatment facilities must satisfy additional standards set forth in 42 CFR part 2.]

1. Name of patient: ____ Phone #: _______________________________________
2. Specific information to be used or disclosed:
   - ☐ Psychotherapy notes
   - ☐ Medical records (describe): ____
   - ☐ Other (describe): ____
3. Entity(ies) authorized to use or disclose the information: ____
4. Entity(ies) to whom disclosure may be made:

   ____
5. Purpose for use or disclosure (check one):
   - ☐ The use or disclosure is at the request of the individual.
   - ☐ The use or disclosure is for marketing purposes. The healthcare provider will / will not (circle one) receive remuneration from a third party for the use or disclosure of information.
   - ☐ Other (describe the purpose): ____
6. This authorization will expire one year from the date of the authorization or until revoked by me in writing.

   ** A minimum of $6.50 will be charged for copies of your medical records.**

   X-ray CDs are free for the first copy and $6.50 for each one thereafter.

I understand that the healthcare provider may not condition treatment on provision of this authorization unless the authorization is for the use or disclosure of information for research-related treatment, or unless the treatment is solely for the purpose of disclosing information to a third party (e.g., an employment physical).

I understand that I may revoke this authorization at any time unless the healthcare provider has taken action in reliance on the authorization. To revoke the authorization, I must submit a written request to: Cindy L. Keene, CEO, Lewiston Orthopaedics, 320Warner Drive, Lewiston, ID 83501.

I understand that information disclosed pursuant to this authorization may be re-disclosed by the recipient and no longer be protected by applicable law.

I have read and understand this authorization. I do hereby authorize the use of disclosure of my protected health information as described above.

Patient Name: ____ Patient DOB: ____________________

Patient Signature: ____ Date: ________________________

If signed by the patient's personal representative, the personal representative hereby states and represents they have been appointed, or have received authorization, to act as the patient's personal representative.

Witnessed by: ____ Date: _________________

Catalyst Medical Group – Lewiston Orthopaedics complies with applicable Federal civil rights laws and does not discriminate on the basis of race, color, national origin, age, disability, or sex.