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**PATIENT AUTHORIZATION FOR PRACTICE TO RELEASE
PROTECTED HEALTH INFORMATION TO THIRD PARTIES**

By signing this authorization, I authorize East Lansing Orthopedic Association to use and/or disclose certain protected health information (PHI) about me to or for the party or parties listed below.

This authorization permits: _____

To use or disclose to: _____

The following individually identifiable health information (specifically describe the information to be released, such as date(s) of service, level of detail to be released, origin of information, etc.). _____

This authorization will expire on _____
(Expiration date or Defined Event).

When my information is used or disclosed pursuant to this authorization, it may be subject to redisclosure 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 East Lansing Orthopedic Association has acted in reliance upon this authorization. My written revocation must be submitted to East Lansing Orthopedic Association's Privacy Officer at 3394 E. Jolly Rd, Suite A, Lansing, MI 48910.

Signed by: _____
Signature of Patient or Legal Guardian

Relationship to Patient

Patient's Name

Date of Birth

Print Name of Patient or Legal Guardian

Date