THE HIRSH CENTER
for ARTHRITIS and SPORTS MEDICINE

Authorization to Release/Disclose Protected Health Information

Patient Name: (Last) _____ **(First)** _____ **(Middle Initial)** ____

Date of Birth: _____/_____/_____ **Phone: ( )** _____

I hereby authorize The Hirsh Center to: ❑ **Release to** ❑ **Request from**

Name: _____ **Phone: ( )** _____ **Fax: ( )** _____

Address: _____ **City/State:** _____ **Zip Code:** _____

This information is to be used for the purpose of:

_____

Information to be released: Date(s) of service requested: From: _____ **To:** _____

❑ **History & Physical** ❑ **Pathology Reports** ❑ **Lab Results** ❑ **X-ray Reports**
❑ **All imaging reports (CT, MRI, U/S, ect)** ❑ **Progress Notes** ❑ **Billing Records** ❑ **Procedure Notes**
❑ **Other:** _____

- This authorization is valid for one year from the signature date. I understand that I can revoke this authorization or extend the date of this authorization in writing. Please note that cancellation of this authorization will not apply to records that may have already been released based on this authorization.
- I understand the information disclosed in response to this authorization may be subject to re-disclosure by recipient and will no longer be protected under the terms of this authorization by federal privacy regulations.
- I understand that this authorization is voluntary and treatment by The Hirsh Center is in no way a condition of whether or not I sign this authorization and that I may refuse to sign it. If I do not sign this form, payment for this care will only be affected if my health care insurer requests this information and is permitted to require this authorization.
- I understand that I may see and copy the information described on this form if I ask for it and based on Florida State Law I may or may not be charged for this information.
- A parent or guardian must sign this authorization if the patient is a minor (under age 18).

Authorization can be sent to:

The Hirsh Center
14610 S. Military Trail, Suite G3
Delray Beach, FL 33484
Fax: (561) 819-3119

Printed Name: _____ **Date:** _____

Signature: _____

*** If signing as a patient representative other than the parent of the minor, proof of authority must be provided."**

If Representative, please check your relationship with the patient:

❑ Parent ❑ Legal Guardian ❑ Executor/Administrator of Estate ❑Healthcare Representative
❑ Conservator ❑ Other Authorized Legal Representative (indicate): _____