

## Patient Authorization Form

I hereby consent to Elizabethtown Orthopaedic Associates (EOA) using or disclosing my protected health information for the purpose of providing treatment to me, obtaining payment for health care services rendered to me or to carry out the Practice's health care operations. I also consent to EOA using or disclosing my protected health information for treatment activities provided by another health care provider, as well as the payment activities conducted by another health care provider or entity. I further consent to the disclosure of my protected health information in order for another provider or health care entity to conduct health care operations including quality assessment and reviewing the competence of health care professionals.

Specific Records Expressly included. I expressly authorize release of the following information for the purposes of treatment, payment and health care operations, if it is part of my protected health information (CHECK ANY OR ALL YOU AGREE TO AUTHORIZE FOR RELEASE):

\_\_\_\_\_ Chemical Dependency/Substance Abuse  
                  \_\_\_\_\_ Drugs \_\_\_\_\_ Alcohol  
\_\_\_\_\_ Sexually Transmitted Diseases

HIPAA requires physicians with a direct treatment relationship to make a good faith effort to obtain an individual's written acknowledgement or receipt of the physician's notice of privacy practices. The acknowledgement must be in writing and HIPAA allows each practice to choose the form and other details of the acknowledgement. An acknowledgement may be obtained, for example, by having the individual sign a separate list or simply initial a cover sheet of the Notice to be retained by the practice. The signature portion below, therefore, is simply one way to comply with the acknowledgement requirement. In addition, physicians who obtain consent from an individual may design one form that includes both a consent and the acknowledgement of receipt of the Notice. The KMA sample consent form contains such an acknowledgement. When electronic notice is provided as part of the first service delivery, the system should be capable of capturing the individual's acknowledgement of receipt electronically. If an individual refuses to sign or otherwise fail to provide the acknowledgement of receipt electronically. If an individual refuses to sign or otherwise fails to provide the acknowledgement, a physician practice must document its good faith efforts to obtain the acknowledgement and reason why the acknowledgement was not obtained.

I further acknowledge EOA has provided me a copy of its Notice of Privacy Practices, which provides a detailed description of the uses and disclosures allowed by this consent, as well as other rights I have regarding my protected health information.

\_\_\_\_\_  
Signature of Patient or Personal Representative

\_\_\_\_\_  
Date

\_\_\_\_\_  
Name of Patient or Personal Representative

\_\_\_\_\_  
Description of Personal Representative's Authority