AUTHORIZATION FOR USE OR DISCLOSURE OF HEALTH INFORMATION

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Confidentiality. This form is used to authorize the release of protected health information in accordance with the Privacy Rule of the Health Insurance Portability and Accountability Act of 1996 ("HIPAA").

Completion of this document authorizes the disclosure and/or use of health information about you.

Patient Name: _____

USE AND DISCLOSURE OF HEALTH INFORMATION

I hereby authorize ROLLIN K. DANIEL, M.D., to release the following information:

- ☐ Copies of Operative Report
- ☐ Photographs
- ☐ Copies of Medical Records

to the following:

Name: _____

Address: _____

City: _____ State: _____ Zip Code: _____

Phone: _____ Fax: _____

Initial the following:

_____ Any facsimile, copy, or photocopy of this authorization shall authorize us to release the records requested herein.

_____ I have been advised of my right to receive a copy of this authorization.

_____
Signature of patient or person authorized to consent

_____ _____
Patient's Name (Print) Date

_____ _____
Patient's Date of Birth Patient's Last 4 Digits of SSN