FREDERICKSBURG ORTHOPAEDIC ASSOCIATES
3310 Fall Hill Ave., Fredericksburg, VA 22401
540-373-4602 | Fax 540-310-0100

ORTHOPAEDICS
JOINT • SPINE • SPORTS • HAND • TRAUMA

Authorization to Use or Disclose Protected Health Information (PHI)

THIS NOTICE DESCRIBES HOW MEDICAL INFORMATION ABOUT YOU MAY BE USED AND DISCLOSED AND HOW YOU CAN GET ACCESS TO THIS INFORMATION. PLEASE REVIEW IT CAREFULLY.

Patient Name: _____ **Date of Birth:** _____

Daytime Phone Number: _____

This authorization permits Fredericksburg Orthopaedic Associates, PC to send or discuss your Protected Health Information (PHI) to **ONLY** the name(s), address or fax number on this form. We **cannot** discuss your PHI with anyone who is not listed by name on this form.

This authorization shall expire on _____. After this date Fredericksburg Orthopaedic Associates, PC can no longer use or disclose the patient's PHI without obtaining a new authorization. If we are providing information to a disability company or attorney, their name and firm name must be listed in the space below. Unless noted your complete medical chart will be available for release. Any exceptions should be listed below.

List names of those authorized for receive PHI _____

_____

_____

_____

List any exceptions unavailable for release _____

_____

_____

The patient has the right to revoke this authorization. In order to be effective, it must be in writing. The revocation will take effect on the date both the patient and the practice have signed it. It must include patient's name, address, and phone number. The patient's reason for revocation, the patient's signature and the date of revocation must be included.

Fredericksburg Orthopaedic Associates, PC will accept revocations of this authorization by certified mail only. This revocation must be sent to the attention of the Privacy Officer, Debbie Catlett at Fredericksburg Orthopaedic Associates, PC 3310 Fall Hill Avenue, Fredericksburg, VA 22401. It is not effective until received and signed by the Privacy Officer. I fully understand and accept the terms of this authorization.

I also acknowledge receipt of the notice of Information Practices provided to me.

_____ _____
Patient or Legal Guardian Date

AP # _____

Consent Form
For Use and Disclosure of Protected Health Information (PHI) for Treatment, Payment, or Healthcare Operations (TPO).

I understand that as part of my healthcare, Fredericksburg Orthopaedic Associates, P.C. originates and maintains health records describing my health history, symptoms, examination and test results, diagnosis, treatment, and any plans for future care and treatment. I also understand this information serves as:

- A basis for planning my care and treatment
- A means of communication among health care professionals who contribute to my care
- A source of information for applying my diagnosis and surgical information to my bill
- A means by which a third party payer can verify that services were actually provided
- A tool for routine health care operations such as assessing quality and reviewing the competence of health care professionals.

I understand and have been provided with a **Notice of Privacy Practices** that provided a more complete description of information uses and disclosures. I understand that I have the right to review the notice prior to signing this consent. I understand the practice reserves the right to change their notice and practices, and prior to implementation, will mail a copy of any revised notice to the address that I have provided if there is a need to use or disclose any protected health information. I also understand that I have the right to restrict as to how my health information may be used or disclosed to carry out treatment, payment or healthcare operations and that the Practice is not required to agree to the restrictions requested, but if it does, it is bound by this agreement. I understand that I may revoke this consent in writing, except to the extent that the practice has already taken action in reliance thereon.

With this consent Fredericksburg Orthopaedic Associates, P.C. may call your home or other designated location and leave a message on voice mail or in person in reference to any items that assist the practice in carrying out TPO, such as appointment reminders, insurance items and any call pertaining to my clinical care, including laboratory results, among others. Any materials sent to my home other then regular billing statements, will be marked Personal and Confidential.

By signing this agreement I am consenting to Fredericksburg Orthopaedic Associates, PC to use and disclose my PHI to carry out my TPO.

If I do not sign this consent, Fredericksburg Orthopaedic Associates, P.C. may decline to provide treatment to me.

Print Patient Name: _____ AP# _____

Signature of Patient or Legal Guardian _____

Date: _____ Patient's D.O.B. _____