Patient Name: _____ Date of Birth:_____

Health Account Number: _____

1. I authorize the use or disclosure of the above named individual's health information as described below.

2. The following individuals or organizations are authorized to make the disclosure:

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Green Valley Orthopedics
1710 W. Horizon Ridge Pkwy #120
Henderson, NV 89012

3. The type of information to be used or disclosed is as follows (check the appropriate boxes and include other information where indicated)

- ☐ Problem List
- ☐ Medication List
- ☐ List of allergies
- ☐ Lab results
- ☐ Operative report
- ☐ Progress notes
- ☐ Consultation reports from (please supply doctor's names):
- ☐ Entire record
- ☐ X-ray and imaging reports and/or disc (please describe the dates or types of x-ray or images you would like disclosed:
- ☐ Other

4. I understand that the information in my health record may include information relating to sexually transmitted disease, acquired immunodeficiency syndrome (AIDS), or human immunodeficiency virus (HIV). It may also include information about behavioral or mental health services, and treatment for alcohol and drug abuse.

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Patient Name: _____ Date of Birth:_____

5. The information identified above may be used by or disclosed to the following individuals or organizations:

   Name:_____
   Address:_____
   Phone Number:_____ Fax Number:_____

   Name:_____
   Address:_____
   Phone Number:_____ Fax Number:_____

6. This information for which I'm authorizing disclosure will be used for the following purpose:

- ☐ my personal records
- ☐ sharing with other health care providers needed
- ☐ other (please describe):

7. I understand that I have a right to revoke this authorization at any time. I understand that if I revoke this authorization, I must do so in writing and present my written revocation to the health information management department. I understand that the revocation will not apply to information that has already been released in response to this authorization. I understand that the revocation will not apply to my insurance company when the law provides my insurer with the right to contest a claim under my policy.

8. This authorization will expire : _____

   If I fail to specify an expiration date or event, this authorization will expire six months from the date on which it was signed.

9. I understand that once the above information is disclosed it may be re-disclosed by the recipient and the information may not be protected by federal privacy laws or regulations.

10. I understand authorizing the use or disclosure of the information identified above is voluntary. I need not sign this form to ensure healthcare treatment.

_____ _____
Signature of patient or legal representative Date

If signed by legal representative, relationship to patient _____

_____ _____
Signature of witness Date

Ronald C. Koe, M.D.
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