MSOC

Michigan SportsMedicine
and Orthopedic Center

www.michigansportsmedicine.com

- **John K. Anderson, MD**
- **John K. Morris, MD**

- Orthopedic Surgery
- Physical Therapy
- Sports Fitness

4972B West Clark Road
Suite 200
Ypsilanti, MI 48197
734.434.3020
734.434.3025 Fax

AUTHORIZATION TO USE OR DISCLOSE PROTECTED HEALTH INFORMATION

I hereby authorize use of disclosure of the named individual's health information as described below:

Patient: _____ DOB: ___/___/___ SS#: _____
LAST FIRST M.I.

Address: _____
STATE ZIP

Telephone: _____

THIS INFORMATION MAY BE DISCLOSED TO AND USED BY THE FOLLOWING PURPOSES:

☐ The request of the patient or patient representative

☐ Other _____

THE FOLLOWING INFORMATION IS TO BE DISCLOSED:

☐ Physician notes

☐ MRI scans

☐ Lab results

☐ Complete record

☐ Xray reports

☐ Other _____

☐ Treatment dates _____

REDISCLOSURE:

I understand that any disclosure of information carries with in the potential for redisclosure and that the information then may not be protected by the federal confidentiality rules.

RIGHT TO REVOKE:

I understand that I have the right to revoke this authorization at any time. I understand that my revocation must be in writing. I also understand that the revocation will not apply to information already released based on this authorization.

OTHER RIGHTS:

I understand that authorizing the disclosure of this health information is voluntary. I can refuse to sign this authorization. I do not need to sign this form to assure treatment. However, if this authorization is needed for participation in a research study, my enrollment in the research study may be denied. I also understand that I may inspect or obtain a copy of the information to be used or disclosed.

EXPIRATION:

Unless otherwise revoked, this authorization will expire 6 months after signed date.

Patient or Legal Guardian Signature: _____ Date: _____

If signed by legal representative relationship: _____ Date: _____