DICKSON ORTHOPEDICS, PA

DBA Jonesboro Orthopaedics and Sports
P.O. Box 1533 • Jonesboro, AR 72403
Ph: (870) 932-1820 • Fax: (870) 972-6712

PATIENT AUTHORIZATION FOR RELEASE, USE OR DISCLOSURE OF PROTECTED HEALTH INFORMATION

By signing this authorization, I authorize the practice of **Brian G. Dickson, M.D., Spencer H. Guinn, M.D., Jeremy P. Swymn, M.D., and Brandon M. Byrd, M.D.** to **obtain from** or **release to** the below-described entity certain Protected Health Information (PHI) about me.

FROM / TO	Dickson Orthopedics, PA	**FROM / TO**	Name: _____
(Circle One)	P.O. Box 1533		Address: _____
	Jonesboro, AR 72403		_____
	Phone: (870) 932-1820		Phone:_____
	Fax: (870) 972-6712		Fax:_____
	Attn: _____		Attn: _____

This authorization permits the practice of **Brian G. Dickson, M.D., Spencer H. Guinn, M.D., Jeremy P. Swymn, M.D., and Brandon M. Byrd, M.D.** to obtain, use, or disclose the following individually identifiable health information about me (specifically describe the information / documents to be released, such as date(s) of services, type of services, level of detail to be released, origin of information, etc.):

_____

_____

The information will be obtained, used or disclosed for the following purpose:

_____

(If requested by the patient, purpose may be listed as "at the request of the individual.")

The purpose(s) is/are provided so that I can make an informed decision whether to allow release of the information.

This authorization will expire on _____
Expiration Date or Defined Event

The Practice will____ will not____ receive payment or other compensation from a third party in exchange for using or disclosing the PHI.

I do not have to sign this authorization in order to receive treatment from this practice. In fact, I have the right to refuse to sign this authorization. When my information is used or disclosed pursuant to this authorization, it may be subject to redisclosure by the recipient and may no longer be protected by the federal HIPAA Privacy Rule. I have the right to revoke this authorization in writing except to the extent that the practice has acted in reliance upon this authorization. My written revocation must be submitted to the Privacy Officer of this practice.

Signed by:_____ _____ _____
Signature of Patient or Legal Guardian | Relationship to Patient | Date

_____ _____
Patient's Printed Name | Date of Birth

Patient/Guardian is to be given a signed copy of this authorization.