ProSport Orthopaedics
James Dettling, MD
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Authorization To Disclose Protected Health Information To Family And/Or Caregivers

In the event **DR. JAMES DETTLING** may need to give your test results or medical information to you, may we................ (check all that apply)

______ Leave a detailed message on an answering machine
______ Leave a message with your spouse or family member
______ Call you on your cellular phone, the number is ______________________________
______ Call you at work, the number is ______________________________
______ Speak to you directly **ONLY**

I, ______________________________(DOB)______________, give Dr. Dettling, Dr. Nagda, and staff, authorization to disclose my protected health information to the following family, friends, and caregivers:

NAME______________________________ Relationship____________________
NAME______________________________ Relationship____________________
NAME______________________________ Relationship____________________
NAME______________________________ Relationship____________________
NAME______________________________ Relationship____________________

I understand that I have the 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 medical records.

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 information shared in the process of treatment, payment, or healthcare operations as sighted in the notice of privacy practices.

I understand that authorizing the disclosure of this health information is voluntary. I can refuse to sign this authorization and I need not sign this form in order to assume treatment. I understand that any disclosure of information carries with it the potential for an un-authorized re-disclosure and the information may not be protected by federal confidentiality rules. If I have questions about the disclosure of my health information, I can refer to my notice of privacy, which I can obtain from the ProSport Orthopaedics office or my doctor's website, www.JamesDettlingMD.net

Unless otherwise revoked, this authorization will expire on the following date, event, or condition: ______________________________. If I fail to specify a date, this authorization will expire one (1) year from the signature date on this form.

______________________________ Date____________________
Signature of Patient

______________________________ Date____________________
Signature of Guardian/Representative

______________________________ Date____________________
Signature of Employee