MICHAEL O. LAGRONE, M.D., P.A. | ORTHOPAEDIC SURGERY
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AUTHORIZATION TO USE OR DISCLOSE PROTECTED HEALTH INFORMATION

PATIENT FOR WHOM AUTHORIZATION IS MADE

Full Name: ______________________________ Other Name(s) Used: ____________________
Date of Birth: ____________________ SSN: ______________________ Account #: ____________________
Address: ____________________________ City: ____________________ State: ________ Zip: ______________
Phone: (_______)______________________________ Email:____

HEALTH CARE PROVIDER OR HEALTH CARE ENTITY AUTHORIZED TO DISCLOSE THIS INFORMATION:

Name: ______________________________________
Address: ____________________________________
City: _______________State: _________ Zip: __________
Phone: (_______)______________________________
Fax: (_______)______________________________

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1600 Coulter, Bldg B
Amarillo, Texas 79106
Phone: (806) 354-2529
Fax: (806) 354-2956

PERSON OR ENTITY WHO CAN RECEIVE AND USE THIS INFORMATION:

Name: ______________________________________
Address: ____________________________________
City: _______________State: _________ Zip: __________
Phone: (_______)______________________________
Fax: (_______)______________________________

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SPECIFIC INFORMATION TO BE DISCLOSED:

□ Medical Record from (insert date) ________________________ to (insert date) ____________________
□ Entire Medical Record, including patient histories, office notes, test results, radiology studies, films, referrals, consults, billing records, insurance records, and records received from other health care providers.
□ Other: ____

REASON FOR RELEASE OF INFORMATION:
(Choose all that Apply)

□ Treatment/Continuing Medical Care
□ Personal Use
□ Billing or Claims
□ Insurance
□ Legal Purposes
□ Disability Determination
□ School
□ Employment
□ Other (Specify): ____________________

This authorization is voluntary. Treatment, payment, enrollment or eligibility for benefits (as applicable) will not be conditioned upon my signing of this authorization form. This authorization shall be in effect until the earlier of two (2) years after the death of the patient for whom this authorization is made or the following specified date: Month: ______Day: ___ Year: __________. I understand that I have the right to revoke this authorization at any time by writing to the health care provider or health care entity listed above. I understand that I may revoke this authorization except to the extent that action has already been taken based on this authorization. This authorization may include disclosure of information relating to DRUG, ALCOHOL and SUBSTANCE ABUSE, MENTAL HEALTH INFORMATION, except psychotherapy notes, CONFIDENTIAL HIV/AIDS-RELATED INFORMATION, and GENETIC INFORMATION only if I place my initials on the appropriate lines above. In the event the health information described above includes any of these types of information, and I initial the corresponding lines in the box above, I specifically authorize release of such information to the person or entity indicated herein.

I have read this form and agree to the uses and disclosure of the information as described. I understand that refusing to sign this form does not stop disclosure of health information that has occurred prior to revocation or that is otherwise permitted by law without my specific authorization or permission. I understand that information disclosed pursuant to this authorization may be subject to redisclosure by the recipient and may no longer be protected by federal or state privacy laws.

SIGNATURES:

____ ______________
Patient/Legal Representative: Date
If Legal Representative, relationship to Patient: ______________________________