Orthopedic Specialists of Seattle

Authorization for Proliance Surgeons, Inc., P.S. to Use or Disclose My Health Care Information

Orthopedic Specialists of Seattle
Ballard Medical Plaza
1801 NW Market Street
Suite 403
Seattle, WA 98107
(206) 784-8833
Fax (206) 784-0676

Seattle Orthopedic Center
2409 North 45th St
Seattle, WA 98103
(206) 633-8100
Fax (206) 633-6107

Philip R. Downer, M.D.
Orthopedic & Sports Medicine
Hip Preservation & Replacement

Jonathan L. Franklin, M.D.
Orthopedic & Sports Medicine
Knee & Shoulder Arthroscopy

Charles A. Peterson II, M.D.
Sports Medicine,
Orthopedic & Fracture Surgery
Total Joint Replacement

Scott D. Ruhlman, M.D.
Orthopedic & Sports Medicine
Hand & Upper Extremity Surgery

Joel A. Shapiro, M.D.
Orthopedic & Sports Medicine
Shoulder & Elbow Surgery

J. Michael Watt, M.D.
Orthopedic & Sports Medicine
Joint Replacement Surgery

Wayne M. Weil, M.D.
Orthopedic & Sports Medicine
Hand & Microvascular Surgery

Brian Haid, PA-C
Agnes J. Hoppe, PA-C
Gail Petteruti, PA-C
Scott J. Taylor, PA-C

PROLIANCE SURGEONS®

Patient Name: _____ Date of Birth: _____

I. My Authorization

You may use or disclose the following health care information (check all that apply):

❑ All health care information in my medical record

❑ Health care information in my medical record relating to the following treatment or condition:

_____

❑ Health care information in my medical record for the date(s): _____

❑ Other (e.g., X rays, bills), specify date(s): _____

You may use or disclose health care information regarding testing, diagnosis, and treatment for (check all that apply):

❑ HIV (AIDS virus)
❑ Sexually transmitted diseases
❑ Psychiatric disorders/mental health
❑ Drug and/or alcohol use

You may disclose this health care information to:

Name (or title) and organization: _____

Address: _____ City: _____ State: _____ Zip: _____

Reason(s) for this authorization (check all that apply):

❑ at my request
❑ other (specify)
❑ check only if practice requests the authorization only for marketing purposes
❑ check only if practice will be paid or get something of value for providing health care information for marketing purposes

This authorization ends: *(This document does not permit disclosure of health information created more than 90 days after the date it is signed.)*

❑ in 90 days from the date signed
❑ on (date): _____
❑ when the following event occurs: _____
(no longer than 90 days from the date signed)

I. My Rights

I understand I do not have to sign this authorization in order to get health care benefits (treatment, payment or enrollment). However, I do have to sign an authorization form:

- To take part in a research study or
- To receive health care when the purpose is to create health care information for a third party.

I may revoke this authorization in writing. If I did, it would not affect any actions already taken by Proliance Surgeons, Inc., P.S. based upon this authorization. I may not be able to revoke this authorization if its purpose was to obtain insurance. Two ways to revoke this authorization are:

- Fill out a revocation form... A form is available from the practice. Or
- Write a letter to the practice.

Once health care information is disclosed, the person or organization that receives it may re-disclose it. Privacy laws may no longer protect it.

_____ _____
Patient or legally authorized individual signature — Date — Time

_____ _____
Printed name if signed on behalf of the patient — Relationship (parent, legal guardian, personal representative)