119 Professional Center, Suite 307 ▪ 1265 Wayne Avenue ▪ Indiana, PA 15701 ▪ Phone: 724.465.2676 (COSM) ▪ Fax: 724.349.1830
Keystone Professional Center, Suite 200 ▪ Punxsutawney, PA 15767 ▪ Phone: 814.938.0740 ▪ Fax: 814.938.0750
Indiana at Chestnut Ridge ▪ 25 Colony Boulevard Suite 109 ▪ Blairsville, PA 15717 ▪ Phone: 724.465.2676 ▪ Fax: 724.349.1830

Center for Orthopaedics & Sports Medicine

(Give to Signer of Release Form)

**AUTHORIZATION FOR RELEASE
OF PROTECTED HEALTH INFORMATION**

RELEASE COSM RECORDS

CENTER FOR ORTHOPAEDICS & SPORTS MEDICINE AUTHORIZATION FOR THE USE OR DISCLOSURE OF HEALTH INFORMATION

By signing a release Authorization, you are permitting the use and/or disclosure of your health information for the limited purposes(s), and in the limited manner, described in the form. Except as authorized by this form, we are required by federal law to maintain the privacy of your health information as described in our Notice of Privacy Practices.

REFUSAL OF SERVICE

If the only reason you have asked us to provide a health care service, is so that we can create information to be disclosed to a third party, we may refuse to provide the service if you refuse to sign this authorization. For example, if you have requested a drug test solely for the purpose of having the results disclosed to your employer, we may refuse to perform the drug test if you refuse to sign this Authorization permitting us to disclose the results to your employer.

Otherwise, your ability to receive treatment, payment, enrollment in a plan, or eligibility for a benefit does not depend on your signing this form. You may refuse to sign this form.
(Note to Employees Presenting This Form: If the treatment of the patient, payment for the patient's care, or enrollment of the patient in a health plan is conditioned on the patient signing this form, no use or disclosure other than that upon which treatment, payment, or enrollment has been conditioned can be authorized on this form. A separate authorization would be needed for any other use or disclosure.)

CONSEQUENCES OF SIGNING THIS FORM

Signing this Authorization may cause the health information used or disclosed pursuant to this Authorization to no longer receive the protections of federal privacy laws. Any person or organization to which your health information is disclosed pursuant to this Authorization might be able to legally re-disclose that information to others.

REVOCATION

You may revoke this Authorization at any time in writing except to the extent that we have already relied upon it in making a use or disclosure. Your written revocation will become effective when we have knowledge of it. If you are providing this Authorization to obtain insurance coverage, you may not have the right to revoke the Authorization to the extent that it pertains to the insurer's right under law to contest a claim under your insurance policy. If you wish to revoke this Authorization, please send your written request to:

Jamie L. Pride, Executive Director
Center for Orthopaedics & Sports Medicine
Privacy Officer/Contact Officer
1265 Wayne Avenue, Suite 307
Indiana, PA 15701

EXPIRATION

Once this Authorization has expired, we will no longer use or disclose your health information for the purpose listed in this Authorization unless you sign a new Authorization form.