

Authorization for Disclosure of Protected Health Information

The Moore Orthopaedic Clinic
Authorization To Disclose Protected Health Information

Client's Full Name

Date of Birth

Social Security Number

Healthy Habitudes, LLC Nutritional Consultation

Name of Program

I authorize The Moore Orthopaedic Clinic to use or disclose Protected Health Information to the following:

Healthy Habitudes

I authorize The Moore Orthopaedic Clinic to use or disclose Protected Health Information for the following purpose(s):

To inform the above named individuals of Participants general wellness and health.

Type of information requested:

Verbal or written protected health information related to general wellness and health that might be affected by a change in diet.

I UNDERSTAND THAT:

- The Protected Health Information used or disclosed under this authorization may be subject to redisclosure by the receiver and no longer protected by the Standards for Privacy of Individually Identifiable Health Information.
- I understand that any treatment may not be conditioned on whether I sign this authorization.
- If I have any questions about the disclosure of my Protected Health Information, I can contact the The Moore Orthopaedic Clinic (803 227-8000).
- I understand that I may revoke this authorization in writing except to the extent that The Moore Orthopaedic Clinic has previously used or disclosed the Protected Health Information in reliance on this authorization. To revoke this authorization, I understand that I must deliver a signed written statement clearly stating that I revoke this authorization to The Moore Orthopaedic Clinic, 104 Saluda Pointe Drive, Lexington, SC 29072.

This authorization expires twelve months from the date of signature, or on: _____.

Authority or Relationship of Representative
(Unless parent, attach copy of documentation of authority,
e.g., a court order designating guardianship)

Signature of Personal Representative/Guardian

Signature of Client

Date