Dr. Daniel C. Eby D.O. PC
Orthopedic Surgery & Sports Medicine

PATIENT AUTHORIZATION FOR DISCLOSURE OF HEALTH INFORMATION

Please print all information, then sign and date form at the bottom

Patient Name: _____ Date of Birth: _____

Patient Address: _____
(Street) (City) (State) (Zip)

Patient Phone Number: _____ Social Security Number:_____

I authorize DANIEL C. EBY D.O. PC to disclose or provide protected health information, about me, to discuss any test results, medical findings, and any financial information with the following people:

Authorized Person: _____ Relationship: _____

Authorized Person: _____ Relationship: _____

Authorized Person: _____ Relationship: _____

Authorized Person: _____ Relationship: _____

Expiration or termination of authorization: This authorization will remain in effect until terminated by you, your personal representative or another individual(s) of legal entity authorized to do so by court order or law.

Right to revoke or terminate: You have the right to revoke or terminate this authorization by submitting a written request to our Privacy Manager. This can be done in-person or by mailing a request to:

DANIEL C. EBY D.O. PC
600 W. 13th Street, Suite 200
Jasper, IN 47546
Attn: Privacy Manager

We have no control over the person(s) you have listed to receive your protected health information. Therefore, your protected health information disclosed under the authorization will no longer be protected by the requirements of the Privacy Rule and will no longer be the responsibility of Daniel C. Eby D.O. PC.

_____ Date: _____
Signature of patient or guardian

Patient Account Number: _____
(To be completed by office personnel)