ORTHO, SPINE & SPORT Clinic
Dr. Mohamed Kilany
Orthopedic and Spine Surgery Specialist

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AUTHORIZATION FOR USE OR DISCLOSURE OF PROTECTED HEALTH INFORMATION

Our Notice of Privacy Practices provides information about how we may use and disclose your protected health information and when we need your written authorization to do so. This form is for use when such authorization is required and complies with the Ortho Spine & Sport Clinic (OSSC) Privacy Standards.

Print Name of Patient: _____

Date of Birth: _____ SSN: _____

I. My Authorization

I authorize the following using or disclosing party:

Ortho Spine & Sport Clinic (OSSC) 120 Al Nasr St. – Dahar – Red Sea Egypt +20 10 1100 50 50 - +20 10 2200 50 50	Dr. Mohamed Kilany Orthopedic & Spine Surgery Consultant info@dr-mohamed-kilany.com

to use or disclose the following health information.

 All of my health information

 My health information relating to the following treatment or condition:

_____

 My health information covering the period of healthcare from (date) _____ to (date)_____

 Other:_____

The above party may disclose this health information to the following recipient:

Name (or title) and organization_____

Address _____

City _____State _____Zip_____

Phone _____Fax _____Email_____

The purpose of this authorization is:

 At my request

 Other: _____

This authorization ends:

 On (date)_____

 When the following event occurs:_____

II. My Rights

- I understand that I have the right to revoke this authorization, in writing, at any time, except where uses or disclosures have already been made based upon my original permission. I may not be able to revoke this authorization if its purpose was to obtain insurance. In order to revoke this authorization, I must do so in writing and send it to the appropriate disclosing party.
- I understand that uses and disclosures already made based upon my original permission cannot be taken back.
- I understand that it is possible that information used or disclosed with my permission may be re-disclosed by the recipient and is no longer protected by the OSSC Privacy Standards.
- I will receive a copy of this authorization after I have signed it. A copy of this authorization is as valid as the original.

Signature of Patient: _____ Date: _____

If the patient is a minor or unable to sign please complete the following:

 Patient is a minor: _____ years of age
 Patient is unable to sign because: _____

Signature of Authorized Representative: _____
Date: _____
Print Name of Authorized Representative: _____

Authority of representative to sign on behalf of the patient:
 Parent Legal Guardian Court Order Other: _____

III. Additional Consent for Certain Conditions

This medical record may contain information about **physical or sexual abuse, alcoholism, drug abuse, sexually transmitted diseases or mental health treatment**. Separate consent must be given before this information can be released.
 I consent to have the above information released.
 I do not consent to have the above information released.

Signature of Patient or Authorized Representative: _____
Date: _____ Time: _____

IV. Additional Consent for HCV/HIV

This medical record may contain information concerning **HCV, HIV testing and/or diagnosis**. Separate consent must be given to have this information released.
 I consent to have the above information released.
 I do not consent to have the above information released.

Signature of Patient or Authorized Representative: _____
Date: _____ Time: _____