

University Specialty Clinics, Department of Orthopaedic Surgery

Authorization to Use/Disclose Information

**Patient's Name:**

**Date of Birth:**

(Check those that apply)

I hereby authorize disclosure of the following protected health information from the medical record of the above-named:

\_\_\_\_\_  
(Describe information to be disclosed, such as portion of the medical record)

Entity Providing Information

**Person or Entity Receiving Information**

USC DEPARTMENT OF  
OTHOAEDIC SURGERY  
TWO MEDICAL PARK, SUITE 404  
COLUMBIA, SC 29203

I hereby authorize University Specialty Clinics, Department of Surgery to use the following protected health information:

\_\_\_\_\_  
(Describe information to be used, such as type of service, date of service)

This protected health information is being disclosed or used for the following **purposes:** \_\_\_\_\_

I understand that if the purpose for use or disclosure of my protected health information is for marketing, University Specialty Clinics may receive direct or indirect payment in connection with the marketing.

I understand that I have the right to refuse to sign this authorization and that University Specialty Clinics, Department of Orthopaedic Surgery will not condition my treatment on whether I provide authorization for the requested use or disclosure.

I understand that for purposes of conducting independent medical exams solely for a third party, University Specialty Clinics will not perform the exam unless I have signed an authorization to release protected health information to the third party.

I understand that information used or disclosed pursuant to this authorization may be subject to re-disclosure by the recipient and may no longer be protected by law.

I understand that I have the right to withdraw this authorization by sending a written notice to University Specialty Clinics, Department of Orthopaedic Surgery, Two Richland Medical Park, Suite 404, Columbia, SC 29203. I understand that withdrawal is not effective for actions taken prior to the withdrawal.

Authorization expires on the following **date or event:** \_\_\_\_\_

\_\_\_\_\_  
**Signature of Patient**

OR

\_\_\_\_\_  
Printed Name of Patient's Representative

\_\_\_\_\_  
Signature of Patient's Representative

\_\_\_\_\_  
**Date of Signature**

\_\_\_\_\_  
Description of Representative's authority to sign for patient