I acknowledge the Practice has provided me a copy of its Notice of Privacy Practices, which provides a detailed description of the uses and disclosures allowed, as well as other rights I have regarding my protected health information.

____
Signature of Patient or Personal Representative

____
Name of Patient or Personal Representative

____
Date

____
Description of Personal Representative's Authority

I, ______________________________, hereby authorize **Ellis & Badenhausen Orthopaedics, P.S.C.** to use and/or disclose my protected health information described below to ____.

My protected health information will be used or disclosed upon request for the following purposes [please name and explain each purpose]:

____
____
____

This authorization for use and/or disclosure applies to the information described below [mark those that apply]:

- o Any and all records in the possession of Ellis & Badenhausen Orthopaedics, P.S.C. including mental health, HIV, and/or substance abuse records. [Cross out any item you do not authorize to be released]
- o Records regarding treatment for the following condition or injury ______________________ on or about ____________________.
- o Records covering the period of time ________________ to ______________.
- o Other [please specify - include dates] ____________________________.

I understand that I have the right to revoke this authorization, in writing, at any time by sending such written notification to **Tom Steltenkamp, ATC - 100 East Liberty Street - Suite 600 - Louisville, KY 40202**. I also understand that my revocation is not effective to the extent that the persons I have authorized to use and/or disclose my protected health information have acted in reliance upon this authorization.

I understand that I do not have to sign this authorization and that **Ellis & Badenhausen Orthopaedics, P.S.C.** may not condition treatment or payment on whether I sign this authorization.

I understand that information used or disclosed pursuant to this authorization may be subject to re-disclosure by the recipient and no longer protected by federal laws and regulations regarding the privacy of my protected health information.

This authorization expires on [please list a specific date or event] ________________.

I certify that I have received a copy of this authorization.

____
Signature of Patient or Personal Representative

____
Name of Patient or Personal Representative

____
Description of Personal Representative's Authority

____
Date

April 14, 2003

I hereby consent to **Ellis & Badenhausen Orthopaedics, P.S.C.** (the "Practice") using or disclosing my protected health information for the purpose of providing treatment to me, obtaining payment for health care services rendered to me or to carry out the Practice's health care operations. I also consent to Practice using or disclosing my protected health information for treatment activities provided by another health care provider, as well as the payment activities conducted by another health care provider or entity. I further consent to the disclosure of my protected health information in order for another provider or health care entity to conduct health care operations including quality assessment and reviewing the competence of health care professionals.

Specific Records Expressly Included. I expressly authorize release of the following information for the purposes of treatment, payment and health care operations, if it is part of my protected health information (CHECK ANY OR ALL YOU AGREE TO AUTHORIZE FOR RELEASE):

- o Chemical Dependency/Substance Abuse
    - ▪ Drugs
    - ▪ Alcohol
- o Sexually Transmitted Diseases

I further acknowledge the Practice has provided me a copy of its Notice of Privacy Practices, which provides a detailed description of the uses and disclosures allowed by this consent, as well as other rights I have regarding my protected health information.

____
Signature of Patient or Personal Representative

____
Name of Patient or Personal Representative

____
Date

____
Description of Personal Representative's Authority

PATIENT NAME ____

DATE OF BIRTH ____

VALIDATION CODE (PASSWORD) ______________________________

PLEASE PROVIDE THIS CODE TO ANY INDIVIDUAL WHO MAY BE INVOLVED IN COORDINATING YOUR CARE OR PAYMENT FOR CARE. THEY WILL BE ASKED FOR THIS VALIDATION CODE (PASSWORD) BEFORE ANY INFORMATION WILL BE RELEASED. THIS WOULD APPLY TO ANY RELEASE OF INFORMATION OVER THE PHONE. (APPOINTMENT TIMES, ETC.)

PATIENT SIGNATURE ___________________________

DATE ____________________________________

PRINT NAME _______________________________

This authorization can only be revoked in writing, please send a written request to:

ELLIS & BADENHAUSEN ORTHOPAEDICS, PSC
100 E. LIBERTY STREET
SUITE 600
LOUISVILLE, KY 40202
ATTN: OFFICE ADMINISTRATOR