Burton F. Elrod, MD
David R. Moore, MD
Jeffrey D. Willers, MD
Thomas T. Dovan, MD
R. Chris Glattes, MD
Chad T. Price, MD
Colin G. Crosby, MD

ELITE
SPORTS MEDICINE + ORTHOPEDICS

Gregory E. Raab, MD
Samuel N. Crosby, MD
Brian Thomson, MD
Amanda D. Martin, DO
Brian D. Dierckman, MD
Elliott J. Kim, MD
John M. Weldy, MD

Patient Name: _____ **DOB:** _____

Authorized Recipient (Who May Receive PHI)

Name/Entity: _____

Address: _____

Phone: _____ Fax/Email (optional): _____

Authorized to Disclose (Covered Entity/Provider)

☐ Elite Sports Medicine + Orthopedics, PLC
☐ MPOWER Physical Therapy

Description of Information to Be Disclosed

☐ Medical History ☐ Treatment Records ☐ Lab/Imaging Results ☐ Imaging Disc
☐ Billing/Claims Info ☐ Other: _____
☐ Period: From _____ to _____ ☐ All past, present, future records

Purpose of Disclosure

☐ Continuity of Care ☐ Legal/Attorney Purposes ☐ Insurance/Claims
☐ Personal Use ☐ Other: _____
(If none selected, "At the request of the individual.")

This authorization expires on: _____ OR upon event: _____
(Date) (such as one year from date of signature)

Patient Rights & Authorization

• I understand that I may refuse to authorize the release of any of my protected health information and that my refusal will prevent the disclosures of such information but will not affect the healthcare services I currently receive or will receive from the practice.
• I understand that I have the right to revoke this authorization at any time by sending a written notification to the practice.
• I understand that revocation will not affect any disclosures made prior to the receipt of the revocation.
• I understand that information disclosed under this authorization may be subject to re-disclosure by the recipient and may no longer be protected by HIPAA

_____ _____
Patient/Representative Signature Date

_____ _____
Print Name of Patient or Legal Guardian Relationship/Authority