

HASTINGS ORTHOPEDIC CLINIC, P.C.
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Form E-2
Authorization for Use or Disclosure of Information

I, _____, _____, _____
Name Date of Birth Social Security Number

hereby authorize Hastings Orthopedic Clinic, P.C., to use or disclose the following protected health information.

Specifically describe the information to be used or disclosed, including, but not limited to, meaningful descriptors such as date of service, type of service provided, level of detail to be released, origin of information, etc.

Protected Health Information is to be released to:

Name _____
Address _____
Phone _____

Protected Health Information to be released from:

Name _____
Address _____
Phone _____

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

(List specific purposes here, the patient may indicate that the information to be is "at the patient's request" if the patient does not choose to provide an explanation of the purpose of the request)

This authorization shall be in force and effect until _____ at which time this authorization to use or disclose this protected health information expires.

I understand I have the right to revoke this authorization, in writing, at any time by sending such written notification to the clinic.

I understand that information used or disclosed pursuant to this authorization may be disclosed by the recipient and may no longer be protected by federal or state law.

Signature of patient (or personal representative) Date

Print Name of Signature Describe Representatives Authority