

**BEACON ORTHOPAEDICS & SPORTS MEDICINE
BEACON ORTHOPAEDICS SURGERY CENTER LLC**

**AUTHORIZATION FOR DISCLOSURE OF
PROTECTED HEALTH INFORMATION**

I, _____, hereby authorize

to disclose my protected health information to:

Beacon Orthopaedics
500 E-Business Way
Cincinnati, Ohio 45241

Beacon Orthopaedics
6480 Harrison Avenue
Cincinnati, Ohio 45247.

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

This authorization shall be in force and effect until

(SPECIFY DATE OR EVENT THAT RELATES TO THE PATIENT OR THE
PURPOSE OF THE USE OR DISCLOSURE) at which time this authorization to use or
disclose this protected health information expires.

I understand that I have the right to revoke this authorization, in writing, at any time.

Name of Patient

Date of Birth

Signature of Patient or Personal Representative

Description of Personal Representative's Authority

Date

Patient's Soc. Sec. Number