



Premier Orthopaedics & Sports Medicine, P.C.  
111 Galway Place  
Suite 300  
Teaneck, NJ 07666  
201-833-9500  
201-862-0095  
APPT@AcesPremOrtho.Com  
AcesPremOrtho.Com

USE AND/OR DISCLOSURE OF PROTECTED HEALTH INFORMATION

Patient Name:

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Date of Birth:

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I authorize the use and/or disclosure of my protected health information as described below.

1. My authorization applies to all of my protected Information, and this information may be used and/or disclosed pursuant to this authorization in accordance with state and federal laws. \*
2. I authorize the following persons (or class of persons) to use and/or disclose my protected health information to the following:
  1.  Physicians and Staff of Premier Orthopaedics & Sports Medicine, P.C., and/or Spine and Trauma Institute(STI), and/or Advanced Center for Excellence in Spine Surgery(ACES), and/or Hand and Trauma Institute (HTI),
3. I authorize my health insurance company and the following persons (or class of persons) to receive my protected health information.
  1.  Family (please list names)  
\_\_\_\_\_
  2.  No-Fault Carriers (Automobile) and adjustors associated with No-Fault (automobile) Medical Insurance Company.
  3.  Workers' Compensation, including adjusters and case managers associated with my case and any insurance claim review companies associated with the Insurance carrier.
  4.  Employer
  5.  Other Individuals/Entities not elsewhere listed : \_\_\_\_\_

I acknowledge that I retain the right to revoke this authorization at any time. However, such revocation must be made in writing to:

Premier Orthopaedics & Sports Medicine, P.C.  
Attn: Privacy Officer  
111 Galway Place  
Suite 300  
Teaneck, NJ 07666  
Fax: 201-862-0095

Further, I understand that any such revocation shall not be effective to the extent that actions have already been taken based on this authorization by the individuals or entities I have authorized to use and disclose my Protected Health Information (PHI). Furthermore, I am aware that if my PHI is disclosed to entities not bound by the federal privacy protection regulations governed by the Health Insurance Portability and Accountability Act (HIPAA), such information may be further disclosed by those entities and may no longer be protected. This authorization shall remain valid for a period of three years following my last date of service with Premier

Orthopaedics & Sports Medicine, P.C., and/or Spine and Trauma Institute (STI), and/or Advanced Center for Excellence in Spine Surgery (ACES), and/or Hand and Trauma Institute (HTI).

I understand that I am not obligated to sign this authorization and that my decision to refuse to sign will not impact my ability to receive treatment or affect my eligibility for benefits with Premier Orthopaedics & Sports Medicine, P.C., and/or Spine and Trauma Institute (STI), and/or Advanced Center for Excellence in Spine Surgery (ACES), and/or Hand and Trauma Institute (HTI).

Further, I grant permission to Premier Orthopaedics & Sports Medicine, P.C., and/or Spine and Trauma Institute (STI), and/or Advanced Center for Excellence in Spine Surgery (ACES), and/or Hand and Trauma Institute (HTI) to disclose or use my Protected Health Information (PHI) for the following purposes:

1. Obtaining Insurance/Medical Coverage Authorization for any medical treatment(s) ordered/requested by our facility(s).
2. Private Insurance Carriers, State, or Federal Entities Making Requests for PHI pertaining to Social Security, Disability Benefits, and/or Disability Status
3. Scheduling appointments and/or referring care to hospitals, outpatient medical facilities, physical therapy facilities, pain management providers/facilities, diagnostic testing facilities, medical labs, and medical imaging facilities.
4. Medical research facilities
5. Collect reimbursement and/or billing for medical services rendered by our offices/providers.
6. Referral to Legal Offices/Attorneys

I acknowledge that I retain the right to revoke this authorization at any time, except to the extent that Premier Orthopaedics & Sports Medicine, P.C., and/or Spine and Trauma Institute (STI), and/or Advanced Center for Excellence in Spine Surgery (ACES), and/or Hand and Trauma Institute (HTI) have already used or disclosed my protected health information (PHI).

I am aware that Premier Orthopaedics & Sports Medicine, P.C., and/or Spine and Trauma Institute (STI), and/or Advanced Center for Excellence in Spine Surgery (ACES), and/or Hand and Trauma Institute (HTI)'s Notice of Privacy Practices is subject to change. If changes occur, I may obtain a copy of the revised notice by calling 201-862-0095.

Furthermore, I understand that I have the right to request Premier Orthopaedics & Sports Medicine, P.C., and/or Spine and Trauma Institute (STI), and/or Advanced Center for Excellence in Spine Surgery (ACES), and/or Hand and Trauma Institute (HTI) to restrict how they use and disclose my protected health information for the purpose of treatment, payment, or healthcare operations. While they are not legally obligated to grant my request, they are bound by our agreement if they choose to do so.

By signing this form, I consent to Premier Orthopaedics & Sports Medicine, P.C., and/or Spine and Trauma Institute (STI), and/or Advanced Center for Excellence in Spine Surgery (ACES), and/or Hand and Trauma Institute (HTI) to use and disclose my protected health information for the purposes as outlined above, as well as, for the purpose of treatment, payment, and other healthcare purposes related to my care.

I have received a copy of this Notice of Privacy Practices and have been allowed to review it. My signature below indicates my agreement with all of the above.

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Client Signature

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Date