

**PATIENT AUTHORIZATION TO DISCLOSE  
CERTAIN HEALTH INFORMATION**

The American Osteopathic Board of Orthopedic Surgery (AOBOS) is a member certifying board of the American Osteopathic Association (AOA). Its board certification process includes a formal written examination. Many of the examination questions/items are based upon patient medical records, including photographic or videotape information from a specific treatment or procedure or case history information drawn from actual patient records. In connection with the exam process, your physician and AOBOS are seeking your consent and authorization to provide certain information to the AOBOS, which will then use the information in its board certification examinations.

I, \_\_\_\_\_ (“Patient”), an individual residing in the State of \_\_\_\_\_, hereby authorize \_\_\_\_\_, D.O. (“Physician”) to release certain patient medical information from my medical records, including photographs, videotapes and/or case histories, to the AOBOS and the AOA.

1. I authorize Physician and/or Physician’s staff to disclose the following information to the AOBOS: photographs, videotapes and/or case histories with respect to Physician’s performance of the following procedure(s) and/or treatment of the following condition(s):

\_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

2. I understand and approve the disclosure of the information to the following persons:
- (a) The board members of the AOBOS and other members of the AOBOS involved in examination construction;
  - (b) The staff of the AOBOS who assist it in developing, preparing and administering the certification examinations; and
  - (c) Individual physicians who take the AOBOS certification examination.
3. I understand that the purpose of the disclosure is to allow for the AOBOS use of the health information in administering its board certification examinations.
4. This Patient Authorization to Disclose Certain Health Information (“Patient Authorization”) is given on condition that neither I, nor any member of my family, will be identified by name in any examination or publication. I understand that in some circumstances the photographs videotapes and/or case histories may, by their nature, portray features or provide information that makes my identity recognizable
5. I understand that I have the right to revoke this Patient Authorization in writing at any time by sending a signed, written statement with my name, date of treatment/procedure, and a

formal statement expressing my desire to revoke this Patient Authorization to Physician's office and/or to the AOBOS at the following address:

American Osteopathic Board of Orthopedic Surgery  
1117 Stone Street, Suite 4  
Port Huron, MI 48060  
FAX: 810-984-2530

If I do not revoke this Patient Authorization, then it shall remain in effect for a period of ten (10) years from the date on which this Patient Authorization is signed.

6. I am completing this Patient Authorization as my free and voluntary act. I understand that my decision to authorize or not authorize the disclosure of information to the AOBOS will not affect my treatment by Physician and that Physician may not make my agreement to provide protected health information to the AOBOS a condition of treatment.
7. I understand that once Physician has provided my records to the AOBOS pursuant to this authorization, the records may be subject to redisclosure by the Board and may no longer be protected by the Health Insurance Portability and Accountability Act of 1996.

By signing this statement on the line indicated, I indicate that I have read, understood and agreed with the terms of this Patient Authorization.

\_\_\_\_\_  
Patient's Signature

\_\_\_\_\_  
Date

\_\_\_\_\_  
Patient's Name

WITNESS/PHYSICIAN: \_\_\_\_\_

**Parental Consent for Minor Patients:**

I am the parent, guardian or conservator of \_\_\_\_\_, a minor and I have legal authority to sign this Patient Authorization on his/her behalf. I have read and understood this Patient Authorization and confirm my agreement with its contents with my signature.

Parent/Guardian \_\_\_\_\_

Date \_\_\_\_\_