Limb Lengthening & Reconstruction Society
Patient consent form for educational display on website

Patient Name:

We understand that information about you and your health is personal, and we are committed to protecting the privacy of that information. Because of this commitment, we must obtain your written authorization before we may use or disclose your protected health information for the purpose(s) described below. This form provides that authorization and helps us make sure that you are properly informed of how this information will be used or disclosed. Please read the information below carefully before signing this form.

USE AND DISCLOSURE COVERED BY THIS AUTHORIZATION

A staff member of our ofiice must fully answer any questions you may have regarding this form. DO NOT SIGN A BLANK FORM. You or your personal representative should read the descriptions below before signing this form.

Who will disclose the information? Health information about you may be disclosed by a physician, nurse or member of our office's staff. This will include clinical and x-ray pictures of you with reference to only your first name.

Who will use and/or receive the information?
We will send this information to our webmaster solely for the purpose of displaying it as educational material on our website, www.LLRS.org and www.LimbLengtheningSociety.org

What information will be used or disclosed?
The following specific information:
- A brief description of your initial problem, your course of treatment, and your end result.
- Digital pictures of you before, during, and after limb reconstruction treatment.
- Digital images of your x- rays.

What is the purpose of the use or disclosure?
The appropriate boxes should be checked below, and the descriptions should be in sufficient detail so that our office staff can understand the purpose(s) for which health information may be used or disclosed.“
- Educational purpose for patients and doctors.

When will this authorization expire?
The date or event that will trigger the expiration of this authorization is:
- If you are not happy with the presentation of your images on our website, then alert your doctor to this fact, and the case presentation will be removed from the Website.

SPECIFIC UNDERSTANDINGS

By signing this authorization form, you authorize the use or disclosure of your protected health information as described above. You should note that when your protected health information is disclosed to people or entities that are not required to abide by federal or state medical privacy laws, those people or entities may re-disclose your information to others and use your information without being subject to penalties under those laws.

You have a right to refuse to sign this authorization. Your health care, the payment for your health care, and your health care benefits will not be affected if you do not sign this form.

You also have a right to receive a copy of this form after you have signed it.

If you sign this authorization, you will have the right to revoke it at any time, except to the extent that our practice has already taken action based upon your authorization. To revoke this authorization, please write to your doctor.

I have read this form and all of my questions about this form have been answered. By signing below, I acknowledge that I have read and accept all of the above.

Signature of Patient or Patient's Personal Representative

____

Print Name of Patient or Patient's Personal Representative

____

Date ____

Description of Personal Representative's Authority

____

The contact information of the patient or personal representative who signed this form should be filled in below.
Address:
____

Telephone:_____________ (daytime)____________(evening)

Email Address (optional):
____

THE PATIENT OR HIS OR HER PERSONAL REPRESENTATIVE MUST BE PROVIDED WITH A COPY OF THIS FORM AFTER IT HAS BEEN SIGNED.