THE ORTHOPEDIC SURGEONS CLINIC
An affiliate of Liberty Hospital

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Permission to Disclose Information to Those Involved in My Care

I hereby allow The Orthopedic Surgeons Clinic to disclose the following information (that apply). This form does not authorize releasing copies of my medical records.:

- o Appointment times and dates
- o Medical information, including my symptoms, diagnosis, medications and treatment plan
- o Tests that have been performed
- o Test results
- o Billing/payment information
- o Other health information (describe)_____

To the following people who are involved with my healthcare and/or payment information: (circle all that apply and list names and telephone numbers)

- o Spouse_____ Phone:_____
- o Friend_____Phone:_____
- o Child(ren)_____ Phone:_____
- o Other_____Phone:_____

Can confidential messages (i.e. appointment information, prescription information, test results) be left on your answering machine or voicemail (circle how you wish to receive messages)?

- o No, DO NOT leave any messages
- o Yes, at home, cell phone or work
- o Yes, only at home
- o Yes, only on cell phone

I understand that in certain situations The Orthopedic Surgeons Clinic may speak to other individuals who are involved in my care or payment of that care, if permitted by law, that may not be identified on this form.

I understand that I have the right to revoke (stop) my permssion at any time. I understand this permission remains in effect until the time I revoke it in writing.

Patient Name (please print):_____Date:_____

Patient/Guardian Signature:_____Date:_____

If patient is a minor, please complete the following information:

Mother's name/contact number:_____

Father's name/contact number:_____