ORTHOPEDIC PARTNERS

Patient Name: _____ DOB: _____

Patient Address: _____

City: _____ State: _____ Zip: _____

Is there a relative / friend that you wish to grant access to your medical and billing information?

By giving permission, you are authorizing access to your complete health record (including records relating to mental healthcare, communicable diseases, HIV or AIDS, and treatment of alcohol or drug abuse treatment) as well as any billing / payment information.

This medical information may be used by the person you authorized to receive this data for medical treatment or consultation, billing or claims payment, or other purposes as you direct. This authorization shall be in force and in effect as of today's date, & will be renewed on an annual basis.

Name	Relationship
Name	Relationship
Name	Relationship

I understand that I have the right to revoke this authorization at any time. I understand that my revocation must be in writing and addressed to the privacy officer of the above named facility authorized to make this disclosure. I understand that the revocation does not apply to information already released in response to this authorization.
I understand that any disclosure of information may be subject to re-disclosure by the recipient and may no longer be protected by federal or state law. I understand that I do not need to sign this authorization to obtain treatment. I understand that I may inspect and/or copy the information to be disclosed. I understand that authorizing this disclosure is voluntary. I understand that if I have questions about disclosure of my health information, I may contact the privacy officer at the facility listed above that is authorized to disclose this information and request a copy of this authorization.

Signature of

Patient/Parent/Legal Guardian: _____ Date: _____

(please use blue or black ink)