ORTHOPEDIC SPECIALISTS, P.C.

PHYSICIANS & SURGEONS

AUTHORIZATION

Patient Name:_____ Date of Birth:_____

Patient to complete the following:

I authorize Orthopedic Specialists, PC to disclose information and/or use the following people to help determine treatment for me: (Please list any family members or friends, such as your emergency contact person, that you would like to give us permission to communicate with.)

_____

_____

_____

This authorization is valid from_____ and expires on_____

I understand that I may refuse to sign this authorization.

I understand that you cannot condition provision of services or treatment based on whether or not I sign this authorization.

I understand that I have the right to revoke this authorization at any time by providing written notice to the organization. I also understand that the revocation is not applicable to information already disclosed while the authorization was in effect.

Signed:_____ Date:_____

Please file in patient chart and provide copy to patient at time of signature.