PROTECTED HEALTH INFORMATION RELEASE
(PATIENTS 18 YEARS AND OLDER)

Please note that by signing this release you are not authorizing us to release your physical records. This authorization is to verbally discuss your healthcare with the individuals you list below.

- ❑ Only release information to me personally.
- ❑ I authorize you to speak with my **adult family members or other individuals** about my medical care and test results as identified below.

Name (please print): _____ Name (please print): _____

Phone Number: _____ Phone Number: _____

Relationship to Patient: _____ Relationship to Patient: _____

Name (please print): _____ Name (please print): _____

Phone Number: _____ Phone Number: _____

Relationship to Patient: _____ Relationship to Patient: _____

- ❑ I authorize you to leave information on my answering machine regarding my medical care and test results.
- ❑ Other, please describe.

_____

_____

HIPAA PRIVACY ACT ACKNOWLEDGEMENT

Allied Orthopaedics and Direct Orthopedic Care are concerned about the privacy of our patient's health care information. Our intent is to make you aware of the possible uses and disclosures of your privacy rights. The delivery of your health care service will in no way be conditioned upon your signed acknowledgement, we will continue to provide you treatment, and will use and disclose your protected health information for treatment, payment and heath care operations when necessary.

I acknowledge that I have received the Notice of Privacy Practices for Allied Orthopaedics and/or Direct Orthopedic Care.

Patient Name (PLEASE PRINT): _____ Date of Birth: _____

Patient/Legal Guardian Signature: _____ Date: _____