



Authorization for Disclosure of Medical Information

With my initials below, Associated Orthopedics and Sports Medicine may use and disclose protected health information about me to carry out treatment, payment and healthcare operations. Please refer to Associated Orthopedics and Sports Medicine's Notice of Privacy Practices for a more complete description of such uses and disclosures. I have the right to review the Notice of Privacy Practices at any time.

With My Consent (please initial only one of the following paragraphs):

_____ (initials) Associated Orthopedics and Sports Medicine (AOSM) may call my home and/or cellular phone to leave a message on my answering machine/voice mail and may leave a message with whomever answers my home phone. AOSM may also send mail or email to my home in reference to any items that assist the practice (AOSM) in carrying out treatment, payment or operations such as appointment reminders, billing information, insurance items and any call pertaining to my clinical care including examination and test (laboratory, etc) results.

_____ (initials) I direct that Associated Orthopedics and Sports Medicine not leave any voice mail messages on my answering machine or speak to anyone in my household other than myself.

I understand that any and all records, whether written, oral or in electronic format are confidential and cannot be disclosed for reasons outside of treatment, payment or healthcare operations. I understand and have been provided with a Notice of Patient Privacy handout that provides a more complete description of information uses and disclosures. I understand that I have the right to request restrictions as to how my health information may be used or disclosed to carry out treatment, payment or healthcare operations and that the office and I must agree on the use and disclosure of my protected health information. A photocopy or fax of this consent is as valid as this original. I understand that I may revoke this consent, in writing, except where disclosures have already been made in reliance on my prior consent.

Patient Signature

Date _____

Printed Name

Date of Birth _____

Email Address

Individual authorized to receive your health information

Telephone Number

Individual authorized to receive your health information

Telephone Number