# PATIENT AUTHORIZATION FORM

## Authorization to Release Information to Family Members

Many of our patients allow family members such as their spouse, significant other, parents or children to call and request the result of tests, procedures and financial information. Under the requirements for H.I.P.A.A. we are not allowed to give this information to anyone without the patient's consent. If you wish to have your medical information, any diagnostic test results and/or financial information released to any family members you must sign this form.

You have the right to revoke this consent, in writing, except where we have already made disclosures in reliance on your prior consent.

**I authorize Family and Friends Orthopedics, PLLC to release my records and any information requested to the following individuals.**

1. _____ **Relation to Patient:**_____
2. _____ **Relation to Patient:**_____
3. _____ **Relation to Patient:**_____
4. _____ **Relation to Patient:**_____

**Authorization Regarding Messages**
**(please check all that apply)**

**____ I authorize you to leave a detailed message on my home or cell number regarding appointments**

**____ I authorize you to leave a detailed message on my home or cell number regarding medical treatment, care, test results or financial information**

**____ I authorize you to leave a message with anyone who answers the phone**

**____ Messages may only be left with _____**

_____ _____
Patient Name (PLEASE PRINT) Date

_____
Patient Signature