



AUTHORIZATION TO DISCUSS TREATMENT

Name: _____ DOB: _____

Chart #: _____

There may be occasions when you want to give another person the ability to discuss your care at Orthopedic Institute with Orthopedic Institute personnel (appointments, billing, treatment, prescriptions, etc).

Examples could include spouse, parent (if you are over 18), another family member, adult child, coach, nursing home representative, care provider, etc. This authorization will allow discussion only. This does not authorize release of medical records.

I give my permission for Orthopedic Institute personnel to share information verbally regarding my treatment at Orthopedic Institute with the following person(s):

Name:	<input type="text"/>	_____
		Relationship
Name:	<input type="text"/>	_____
		Relationship
Name:	<input type="text"/>	_____
		Relationship

For additional names, please list on back.

There may be occasions when Orthopedic Institute needs to contact you to discuss your care.

I give Orthopedic Institute permission to contact me by phone at the following numbers:

Home:	(____) _____	Leave Message	Yes ____	No ____
Work:	(____) _____	Leave Message	Yes ____	No ____
Cell:	(____) _____	Leave Message	Yes ____	No ____

I give my permission for Orthopedic Institute personnel to leave messages regarding appointments, treatment, etc. and to release verbal information as indicated above.

Signed _____ Date _____

<p>For Staff Use Only: Permission via phone call</p> <p>Verbal permission given to: _____ (Employee) _____ (Date)</p>
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