

Institute for Orthopedic Surgery and Sports Medicine

CONSENT TO RELEASE OF PATIENT INFORMATION TO FAMILY MEMBERS, FRIENDS, OR OTHERS

1. I hereby authorize the Institute for Orthopaedic Surgery and Sports Medicine to release any information including, if any, psychiatric or psychological information, infectious, or contagious disease information including HIV/AIDS confidential information, and/or information about drug or alcohol or treatment of the same from the health records of:

Patients Name _____ Account # _____

Date of Birth _____ SS# _____

2. The following individuals are authorized to receive and discuss my medical information:

Name: _____ Relationship _____

Phone # _____

Name _____ Relationship _____

Phone # _____

3. I hereby release Dr's Fifer, Heligman, Gomez, Markovich, Hood, Follweiler, Kleiman and their employees, agents, officers, and affiliates from any and all liability, responsibility, claims and damages which may result from the release of information authorized by this consent for release of information.

4. I have read and understand the consent for release of information and have voluntarily and knowingly signed such consent for any and all dates of service.

5. Exceptions to the release: _____

6. Security validation : Mothers maiden name - _____

Date: _____

Signature of Patient

Signature of Representative (if patient unable to sign)

Relationship to patient

Any changes to this authorization must be received in writing.