

AUTHORIZATION to DISCLOSE HEALTH INFORMATION

I, _____, give my consent for Family Orthopaedics & Rehabilitation Center, LLC to release medical and billing information to the following person(s):

Name:	Relationship to Patient:
_____	_____
Name:	Relationship to Patient:
_____	_____
Name:	Relationship to Patient:
_____	_____
Name:	Relationship to Patient:
_____	_____
Name:	Relationship to Patient:
_____	_____
Name:	Relationship to Patient:
_____	_____
Name:	Relationship to Patient:
_____	_____
Name:	Relationship to Patient:
_____	_____

I also understand that it is my responsibility to notify Family Orthopaedics & Rehabilitation Center, LLC of any changes to this authorization. **This authorization is valid indefinitely unless we receive written notification of requested changes.**

I give Family Orthopaedics & Rehabilitation Center, LLC permission to leave messages regarding my test results, appointment reminders, and any other information pertaining to my medical record on/with:

- Voice Mail
 Answering Machine
 Family Member
 Other

Signature of Patient, Parent, or Legal Guardian

Date

Printed Name of Patient, Parent, or Legal Guardian

Date

Signature of Witness Family Orthopaedics & Rehabilitation Center

Date