

AUTHORIZATION to DISCLOSE HEALTH INFORMATION

I, _____, give my consent for Major Sports Medicine 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 Major Sports Medicine of any changes to this authorization. **This authorization is valid indefinitely unless we receive written notification of requested changes.**

I give Major Sports Medicine 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 Major Sports Medicine Date