Abilene Bone & Joint

Authorization To Share Medical Information

On occasion there may be a need to discuss your medical care, test results, etc., with other people such as family members. You may also wish others to be able to obtain copies of your records. Privacy laws prevent us from automatically giving this information to anyone other than the patient (or guardian) or other medical providers involved in your care. If you would like your medical information shared with anyone else, please provide their names in the spaces provided below.

Information regarding my medical care may be shared with:

_____

_____

_____

_____

Emergency Contact Information:

Name: _____

Phone Number: _____

Relationship to patient: _____

The purpose of this release is to provide information regarding my care at the Abilene Bone & Joint.

I understand that I may revoke this authorization (in writing) at any time except to the extent that action has been taken in reliance on it and that, in any event, this authorization will not expire until and unless I revoke it.

I understand that the Abilene Bone & Joint will not condition my treatment, payment, enrollment in a health plan or eligibility for benefits (if applicable) on whether I provide authorization for the requested use or disclosure.

I understand that authorizing the disclosure of this health information is voluntary, I need not sign this form in order to assure treatment. I understand that I may inspect or copy the information to be used or disclosed. I understand that this disclosure may be subject to re-disclosure and no longer be protected by federal confidentiality rules.

Date: _____ Signature: _____
(Patient, Parent, or Legal Guardian)

_____
(Relationship to Patient)

Name: _____ DOB: _____