THE CENTER
ORTHOPEDIC & NEUROSURGICAL CARE & RESEARCH

Health Information Management
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HIPAA CONSENT TO SHARE INFORMATION

Patient Name: _____ **DOB**_____ **MRN**_____

Phone: _____**May we leave a message?** ❒ Yes ❒ No

By Law, The Center requires your authorization in order to communicate with:

1. Your spouse
2. Your adult children or caregivers
3. Your parents (if you are older than 18)

The Center may need to communicate with your family or caregivers in the following circumstances:

1. Making and confirming appointments
2. Discussing treatment needed or performed
3. Account or Financial Information

Please indicate below who we may communicate with if you are not available. Please provide the name of the individual and current phone number:

❒ Spouse _____Phone Number: _____

❒ Child(ren)_____ Phone Number:_____

❒ Other _____ Phone Number: _____

❒ **Information <u>not</u> to be released to anyone.**

If unable to reach me:

❒ You may leave a detailed message
❒ A message asking to return your call
❒ **You may <u>not</u> leave a message**

By signing this authorization, I understand that:

- This authorization for participation in my care shall remain valid indefinitely or until formally revoked in writing.
- This form does not authorize the release of medical records. You must personally sign the Authorization to Disclose Health Information in order to obtain a copy of your health records.
- If you appoint an individual to pick up medical records on your behalf from the Health Information Management Department they will be required to show a valid photo ID.

Patient Signature: _____Date_____

Patient Guardian or Legal Representative: _____ Date_____

Printed Name of Guardian or Legal Representative: _____

*Please note: Copy of proof of legal representation must be provided at the time of request, if not previously on file with The Center