Patient Authorization to Verbally Discuss Health Information

This form allows Orthopedic Institute, PLLC to verbally discuss your protected health information with designated people.

Patient Name: _____ Date: _____

Address: _____

City: _____ State: _____ Zip Code: _____

Phone: _____ Email: _____

Complete this Patient Authorization to Verbally Discuss Health Information ("Release") form to provide Orthopedic Institute, PLLC with consent to verbally discuss your protected health information with your family, friends and third-parties you designate who are involved in your medical care and may ask questions about your condition or need information when you are not present. This Release will not allow Orthopedic Institute, Inc. to provide access to or release your medical records.

Fax this completed form to: **480-546-6989**

You may complete more than one Patient Authorization to Verbally Discuss Protected Health Information forms.

I authorize Orthopedic Institute, Inc. to verbally discuss the following protected health information about me with the following, including translation from/to another language:

Patient Name: _____ Date: _____

Address: _____

Phone: _____ Email: _____

Check all boxes that apply:

_____ Appointment and Scheduling Information _____ Lab/Test Results

_____ Billing and Payment Information _____ Medical Imaging Results

_____ All medical records and Information including but not limited to symptoms, diagnosis, medication and treatment plan

_____ My location in the facility, whether I am waiting to go into surgery or the procedure room, in recovery or have been discharged.

_____ Provide any and all requested protected health information to the person I designated in this Release.

I understand that I have the right to revoke or modify this Release form at any time, for any reason or no reason at all. I also understand and agree that if I revoke or modify this Release, I must do so in writing and present my written request to Orthopedic Institute, PLLC. Additionally, I acknowledge that it is my responsibility to confirm receipt by Orthopedic Institute, PLLC of such revocation or modification; such confirmation is required via certified mail. I understand and agree that the revocation or modification will not apply to information previously released in response to this Release. I understand and agree that once the protected health information is disclosed, it may be redisclosed by the recipient and the information may not be protected under federal privacy laws or regulations.

I understand Orthopedic Institute, PLLC will not condition treatment or payment based on or revocation of this Release form unless otherwise allowed by law. A copy of this Release form may be utilized with the same effectiveness as an original. I am entitled to receive a copy of this Release.

Signature: _____ Date: _____
Patient/Guardian/Power of Attorney/Health Care Surrogate

Patient's Name: _____ Relationship to Patient: _____