SOUTHWEST SHOULDER ELBOW & HAND CENTER

Release to Disclose Information

In a matter of communicating with you regarding test results or account information it may be preferable for you to speak to a family member or to leave you a message. Your privacy is of the utmost importance to us, so we will look for your authorization below that authorizes us to speak with anyone on your behalf or leave detailed messages.

If you are unavailable, may detailed messages be left for you on home answering machines or personal voice mail? Yes ☐ No ☐

If yes, please give the appropriate numbers:

☐ _____

☐ _____

☐ _____

May we have standing permission to discuss your health issues or billing issues with one or more family members? You do not need to allow us to speak to anyone, but realize if your family member or caregiver calls in for any reason, they will not be able to receive information unless written permission is given.

Southwest Shoulder Elbow and Hand Center, P.C. may share information with:

		Name:	**Relationship:**
☐ Billing Issues	☐ Health Issues	_____	_____
☐ Billing Issues	☐ Health Issues	_____	_____
☐ Billing Issues	☐ Health Issues	_____	_____

I hereby authorize Southwest Shoulder, Elbow and Hand, PC to use and disclose my individually identifiable health information as described above. I understand that this authorization is voluntary. I understand that once this information is disclosed to the party named above the released information may no longer be protected by federal privacy regulations.

I understand that I may revoke this authorization at any time by notifying Southwest Shoulder, Elbow and Hand, PC in writing; however, if I do revoke the authorization, it will not have any effect on any actions taken by Southwest Shoulder, Elbow and Hand, PC prior to their receipt of the revocation.

_____ _____

Patient or patient representative signature Date

_____

Print Name Relationship if patient representative

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