

STRAND ORTHOPAEDIC CONSULTANTS

PREFERENCES ON DISCLOSURE OF MY PROTECTED HEALTH CARE INFORMATION

Patient Name: _____ Date of Birth: _____

LEGAL PARENT OR GUARDIAN NAME: _____

Strand Orthopaedic and your physician abide by federal and state laws concerning the protection and confidentiality of health care information. As your health care provider, it may at times be necessary to share health care information with other health care providers, such as specialists, laboratories, consulting medical providers, radiologists, and other pertinent health care providers in meeting your health care needs. Information may be shared with your insurance carrier, and/or for billing purposes. Please read our "**NOTICE OF PRIVACY PROTECTION**" for complete information on how your health care information will be handled by our office.

There may be other persons that you want your protected health care information shared with, such as family or significant others. **We will at all times comply with federal and state laws pertaining to your protected health care information**, while respecting your rights to allow that information to be shared in matters concerning your health care, and at your written request. Please advise us of your wishes concerning disclosure of information pertaining to your confidential, protected health information by completing this form in full.

This form and the information you give us will become a permanent part of your confidential medical record. It will be effective from the original date and signature for as long as we hold your medical record or until you give us notice in writing to revoke it. **You may change or revoke this authorization at any time by notifying us in writing.** In some instances, information may have been released before we received written notification to change or revoke this information.

We cannot ensure the privacy of your telephone conversations if you call our office on a cellular telephone.

___ **I authorize** Strand Orthopaedic to call and leave messages concerning my health care on my answering machine.
___ at home ___ at work ___ cell phone Cell Number is _____

___ **I authorize** Strand Orthopaedic to call, and in my absence, leave messages concerning my health care with the following person(s) listed below: (List names and relationships). Please tell us how we will be able to identify this particular person over the telephone before we leave messages, i.e.; nickname, birth date, password, etc.

List Names(s) _____
Nickname _____ Birthdate / Password _____

What information may we leave with this person? ___ Appointment reminder ___ Test results
___ Billing ___ Other (specify) _____

___ **I authorize** Strand Orthopaedic to send health information by mail to my home.

___ **I authorize** Strand Orthopaedic to fax my medical information / bills to: _____

___ I would like any prescriptions or medications called to the following pharmacy:
Pharmacy name: _____ Location: _____ Pharmacy number: _____

___ **I authorize** Strand Orthopaedic to release my medical records to my attorney.
Attorney Name: _____ Telephone number: _____

Who would you like notified in case of an emergency? _____
Relationship _____ Telephone _____

Please list any other information you would like us to know and observe in caring for your health care needs and protecting that health care information.

Patient Signature _____ Date _____