Parkcrest Orthopedics
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OPEN AUTHORIZATION TO RELEASE PROTECTED HEALTH INFORMATION

PATIENT NAME: _____ DOB: _____

HOME ADDRESS: _____

I hereby authorize Parkcrest Orthopedics to release any and all protected health information maintained in my medical records to the following individuals, concerning my status as a patient, treatment or payment of services provided by Parkcrest Orthopedics.

NAME RELATIONSHIP TO PATEINT

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This authorization is given freely with the understanding that this authorization is valid until revoked by law. I may revoke this authorization at any time, except where information has already been released. Individuals not listed on this form will be unable to receive any information. Parkcret Orthopedics and its workforce are hereby released from any legal responsibility or liability for disclosure of any of my Protected Health Information as indicated and authorized herein.

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PATIENT'S NAME DATE

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PATIENT'S SIGNATURE (OR PARENT OR LEGAL GAURDIAN IF A MINOR)

NOTICE OF PRIVACY PRACTICES

-I acknowledge that, if needed, I may request a summary of Parkcrest Orthopedics' notice of privacy practices and concern to the use or disclose of my protected health information by Parkcrest Orthopedics for the purpose of diagnosing or providing treatment to me, obtaining payment for health care operations Parkcrest Orthopedics and as required by law.
-I also acknowledge that the entire notice is available at Parkcrest Orthopedics' front desk and that I understand that I may obtain a full version of this notice at this time. I understand my rights as a patient of this practice concerning my Protected Health Information, as it is outlined in this notice. I am aware Parkcrest Orthopedics reserves the right to change the privacy practices that are described in this notice. I may obtain a revised notice by contacting the office and requesting a copy be sent in the mail or asking for one at the time of my next appointment.

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PATIENT'S SIGNATURE (OR PARENT OR LEGAL GUARDIAN IF A MINOR)

AUTHORIZATION TO PAY BENEFITS TO PHYSICIAN

-I authorize payment of benefits, as determined by Parkcrest Orthopedics, directly to Surgeon/Physician (please circle) YES NO I understand that unless I have circled YES above, I may still be responsible for any amounts not paid by my Insurance Company in the event that the charges made are not reasonable and customary.
-We ask that all patients give at least 24 hours' notice that the will be unable to keep their appointment.

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PATIENT'S SIGNATURE (OR PARENT OR LEGAL GUARDIAN IF A MINOR)