ORTHOPEDIC & SPORTS
INSTITUTE OF THE FOX VALLEY™

Orthopedic and Sports Institute of the Fox Valley

Permissions to Verbally Discuss Health Information

You can give us permission to discuss information about you with family, friends, and others you designate who are involved in your care, concerned about your health status and may ask about your condition, or help you with payment of your bills. You can tell us who we may talk with about your medical care, including your appointment and scheduling information, lab, and test results, and billing information. This does not mean that the person will have access to your medical records.

Complete this form to let us know to whom we may speak about your information. Check the appropriate boxes to indicate what information we may discuss. Here are some examples of when it might be useful to you to release information:

- If you want a relative or friend to help understand medical treatment instructions
- If you want a relative of friend to help you understand your bills
- If a relative or friends comes in and asks if you are here

This authorization that I am providing is effective until my legal representative or I cancel it. This authorization does allow Orthopedic and Sports Institute of the Fox Valley (OSI) to provide or release copies of my medical and billing records to anyone as this requires a separate authorization.

☐ Do not provide my health information to anyone

I give permission to OSI to discuss the following information about me with the following person(s) (*Check all boxes that apply for each person you list*):

1. Medical information, including my symptoms, diagnosis, medications, lab test results, results of a procedure
2. Appointment instructions including treatment plan, appointment dates, and follow-up appointment information
3. Insurance, billing, and payment information
4. My location in the facility

Full Name	Relationship	Phone #	1	2	3	4
			☐	☐	☐	☐
			☐	☐	☐	☐
			☐	☐	☐	☐
			☐	☐	☐	☐
			☐	☐	☐	☐

I am not required to sign this form in order to be provided treatment, payment, enrollment in a health plan, or eligibility for benefits. The persons(s) I am authorizing to receive my health information may release my health information without my knowledge and may not be required to follow federal or state privacy standards.

I may cancel this authorization to release my health information by completing and providing a new completed form to the appropriate OSI clinic business office. Cancellation does not apply to health information already released in response to this authorization. I understand that if someone not listed above requests information about me, the request will be denied.

I understand what health information about me will be released. This accurately reflects my wishes.

______________________________ ________________ ________
Signature of Patient/ Authorized Legal Representative* Date Time

***Name of the Legal representative completing this form:** ______________________________

Legal authority*: ☐ Parent **By signing above, I am confirming that I have not been denied physical placement of this child
☐ Legal guardian ☐ Next of kin / executer of deceased ☐ Activated POA for Health Care ☐ Other: ______________

Patient Sticker

Template last updated 4/19/17