SEACOAST ORTHOPEDICS & SPORTS MEDICINE

HIPAA Disclosure Agreement

Patient Name: _____ Date of Birth: _____

I hereby grant permission for Seacoast Orthopedic Associates to verbally discuss my personal health information to the following individual (s) named below.

Name: _____ Relationship: _____ Phone number: _____

Name: _____ Relationship: _____ Phone number: _____

Name: _____ Relationship: _____ Phone number: _____

☐ Appointments: Ability to make, change or cancel appointments on my behalf

☐ Medical records: Including but not limited to: office visits, MRI reports, lab work

☐ Billing Questions/payments

☐ Other: _____

☐ **Do not discuss my medical records/appointment history/billing items with anyone**

Emergency Contact Name: _____ Phone #: _____

****Please note the Emergency Contact will *not* have access to your appointments, medical records, or billing****

I understand that this permission may be revoked by me at any time by notifying Seacoast Orthopedic Associates in writing, but that revoking it will not affect any information that has already been released.

_____ _____

Patient Signature or Legal Guardian Date

For Office use only: scan as Authorization to Release

Updated April 2022