

MEDICAL INFORMATION RELEASE

I, THE UNDERSIGNED PATIENT, UNDERSTAND AS A PATIENT OF THE SPORTS MEDICINE CENTER THAT MY PATIENT HEALTH INFORMATION (PHI) MAY BE REVIEWED BY PHYSICIANS OR MEDICAL PROVIDERS OTHER THAN MY IMMEDIATE PHYSICIAN, TO INCLUDE BUT NOT RESTRICTED TO MY PRIMARY CARE PHYSICIAN AND ANY REFERRAL PHYSICIANS OR PROVIDERS DEEMED BY MY PHYSICIAN TO BE INSTRUMENTAL IN MY CARE.

Must select one of the options below and sign below.

Option (1) BY MY SIGNATURE BELOW, I **AUTHORIZE** THE SHARING OF MY PATIENT HEALTH INFORMATION AS DESCRIBED ABOVE, AT THE DISCRETION OF THE PHYSICIANS OF SPORTS MEDICINE CENTER, **FOR TREATMENT PURPOSES ONLY.**

Option (2) BY MY SIGNATURE BELOW, I **REFUSE** AUTHORIZATION TO THE PHYSICIANS OF SPORTS MEDICINE CENTER TO RELEASE OR SHARE MY PATIENT HEALTH INFORMATION WITH ANY SOURCE OUTSIDE OF THE SPORTS MEDICINE CENTER- EXCEPT AS NECESSARY FOR REIMBURSEMENT.

I UNDERSTAND THAT COMMUNICATIONS FROM THIS OFFICE REGARDING APPOINTMENTS, PRESCRIPTIONS AND/OR TEST RESULTS, MAY INVOLVE PHONE CONVERSATIONS OR MESSAGES LEFT AT MY HOME VIA ANSWERING SERVICES AND MACHINES, OR WITH ANOTHER FAMILY MEMBER.

Must select one of the options below and sign below.

Option (1) BY MY SIGNATURE BELOW, I **AUTHORIZE** THE LEAVING OF MESSAGES ON MY MACHINE OR ANSWERING SERVICE OR SPEAKING WITH ANOTHER FAMILY MEMBER AT MY HOME.

**YOU MAY SPEAK WITH, _____
REGARDING APPOINTMENTS, PRESCRIPTIONS AND/OR TEST RESULTS.**

Option (2) BY MY SIGNATURE BELOW, I **REFUSE AUTHORIZATION** TO LEAVE MESSAGES ON MY MACHINE OR ANSWERING SERVICE OR WITH ANOTHER FAMILY MEMBER AT MY HOME, ABOUT ANYTHING OTHER THAN TO RETURN YOUR CALL.

ALTERNATE PHONE # FOR YOU TO REACH ME AT: _____

EMAIL ADDRESS: _____

PATIENT NAME: _____

PATIENT SIGNATURE: _____

WITNESS: _____ DATE: _____