South Alabama Orthopedics & Sports Medicine, P.C.

Patient Consent to the Use and Disclosure of Health Information

for Treatment, Payment or Healthcare Operations

I, ____ understand that as part of my healthcare, South Alabama Orthopedics & Sports Medicine, P.C. originates and maintains paper and/or electronic records describing my health history, symptoms, examination and test results, diagnoses, treatment, and any plans for future care or treatment.

I understand and have been provided with a *Notice of Privacy Practices* that provides a more complete description of information uses and disclosures.

Patient or Guardian's Signature_______________________________

Date ____________________

(MM/DD/YYYY)

Please list below the names of any individuals who we may disclose any medical and/or account billing information on your behalf. These people will be allowed to act as your personal representative.

NAME ______________________________ RELATIONSHIP ______________

NAME ______________________________ RELATIONSHIP ______________

NAME ______________________________ RELATIONSHIP ______________

NAME ______________________________ RELATIONSHIP ______________